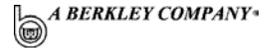


# Berkley Life and Health Insurance Company



Urbandale, Iowa

Underwriting Office:  
2445 Kuser Road, Suite 201  
Hamilton Square, NJ 08690

## Stop Loss Insurance Policy

**Policyholder:** City of Carrollton  
**Policy Number:** ERL L16101095 001  
**Original Policy Effective Date:** 01/01/2016

**Berkley Life and Health Insurance Company** (“the Company”) agrees to reimburse the Policyholder as outlined under the provisions of this Stop Loss Insurance Policy (“this Policy”), subject to all the terms and conditions of this Policy.

This Policy is legally binding between the Policyholder and the Company. This Policy is issued in consideration of the application and the payment of premiums as provided hereinafter.

The first premium is due on the first day of the Policy Period. Subsequent monthly premiums are due on the first day of each month thereafter. The premium is not considered paid until the premium payment is received by the Company.

All periods of coverage will begin and end 12:01 a.m. Standard Time at the principal office of the Policyholder.

This Policy is governed by the laws of the state in which it was issued except to the extent to which such state law is pre-empted by ERISA.

Signed for the Company:

Handwritten signature of Christopher C. Brown in cursive.

President

Handwritten signature of B. W. Mc in cursive.

Secretary

**PLEASE READ THIS POLICY CAREFULLY  
ISSUED TO THE POLICYHOLDER IDENTIFIED ON THE SCHEDULE OF INSURANCE**

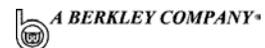
**This Policy is Non-Participating**

Berkley Life and Health Insurance Company is a member company of the W.R. Berkley Corporation .

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# Berkley Life and Health Insurance Company



Urbandale, Iowa

Underwriting Office:  
2445 Kuser Road, Suite 201  
Hamilton Square, NJ 08690

## Schedule of Insurance

**Policyholder:** City of Carrollton

**State of Issue:** TX

**Policy Number:** ERL L16101095 001

**Original Effective Date:** 01/01/2016

**Policy Period** January 1, 2016 through December 31, 2016

**PERSONS TO BE COVERED UNDER THE STOP LOSS POLICY:** Covered Person(s) who meet the eligibility requirements as set forth under the Policyholder's employee benefit Plan, including:

- Retired Employees
- COBRA Continuees

**AGGREGATE STOP LOSS**       Yes     No

**Benefit Period:**

Losses Incurred from 01/01/2015 through 12/31/2016  
 and Paid from 01/01/2016 through 12/31/2016

**Plan Coverages applying to Aggregate Stop Loss:**

<u>Included</u>	<u>Not Included</u>		<u>Included</u>	<u>Not Included</u>	
[X]	[]	Medical	[]	[X]	Vision Care
[X]	[]	Prescription Drugs	[]	[X]	Disability Income
[]	[X]	Dental Care	[]	[X]	Other _____

**Aggregate Percentage Reimbursable** (Excess of Attachment Point) 100% all covered Plan benefits

**Monthly Aggregate Factors:**

	<u>Composite</u>			
Medical	\$1,134.78	\$	\$	\$
Dental	\$	\$	\$	\$
Vision	\$	\$	\$	\$
Disability Income	\$			
Other	\$	\$	\$	\$

All included coverages are combined for determination of Aggregate Stop Loss liability under the terms of this Policy.

Maximum Aggregate Benefit per Benefit Period (Excess of Annual Aggregate Attachment Point)	<u>\$1,000,000</u>
Maximum Plan Losses per Covered Person per Benefit Period	<u>\$225,000</u>
Minimum Annual Aggregate Attachment Point	<u>\$10,417,291</u>

**SPECIFIC STOP LOSS**

Yes  No

**Benefit Period:**

Losses Incurred from 01/01/2015 through 12/31/2016  
and Paid from 01/01/2016 through 12/31/2016

Losses Incurred prior to the original Policy Effective Date will be limited to \$0.00 per Covered Person

**Plan Coverages applying to Specific Stop Loss:**

<u>Included</u>	<u>Not Included</u>		<u>Included</u>	<u>Not Included</u>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Medical	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Vision Care
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Prescription Drugs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Disability Income
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Dental Care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Other _____

Specific Deductible (Per Covered Person) \$ 225,000

Special Limitations: The group will waive the requirements of section 1550.052 and 1550.053 of the Texas Insurance Codes Statutes.

Aggregating Specific Deductible (if Aggregating Specific Endorsement is selected) N/A

Specific Percentage Reimbursable (Excess of Deductible) 100% all covered Plan benefits

Annual Maximum Specific Benefit (per Covered Person in excess of the Specific Deductible) Unlimited

**PREMIUMS**

Aggregate Premium per (month/annum):	Employee	<u>\$2.88</u>
Specific Premium per month:	Employee	<u>\$28.21</u>
	Employee & Family	<u>\$88.11</u>

**ENDORSEMENTS ATTACHED:**

- |   |                 |
|---|-----------------|
| <input checked="" type="checkbox"/> Specific Simultaneous Funding               | <u>Included</u> |
| <input checked="" type="checkbox"/> No New Special Limitations and Rate Cap 45% | <u>Included</u> |
| <input checked="" type="checkbox"/> Actively at Work                            | <u>Included</u> |
| <input checked="" type="checkbox"/> Appeals                                     | <u>Included</u> |

**DESIGNATED TPA:**

TPA Name TML Intergovernmental Employee Benefits Pool
--

Address	City	State	Zip
1821 Rutherford Lane, Ste 300, Austin, TX 78754			

## Definitions

**ANNUAL AGGREGATE ATTACHMENT POINT** for any one Policy Period means the greater of:

- the sum of the Monthly Aggregate Attachment Points; or
- the Minimum Annual Aggregate Attachment Point.

**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 Effective Date, Policy Period, or waive the Policy's eligibility requirements.

**CLINICAL TRIALS** means an ongoing Phase I, II, or III clinical trial as defined by the National Institutes of Health, National Cancer Institute, or the Food and Drug Administration (FDA).

**COVERED PERSON** means any one individual enrolled and entitled to benefits under the specific terms and provisions of the Plan. Only eligible classes and individual(s) whose initial and continued eligibility is fully described in the copy of the Plan on file with the Company and shown in the Policy schedule shall be considered a Covered Person.

**COVERED UNIT** means the following person or persons who are covered under the Plan:

- A Covered Person
- A Covered Person with Dependents
- Such other defined unit as agreed upon between the Company and the Policyholder.

**COVERED SERVICES** means the benefit provisions contained within your Plan that are not specifically excluded under this Policy.

**DESIGNATED THIRD PARTY ADMINISTRATOR (DESIGNATED TPA)** means a firm or person which has been retained by the Policyholder to pay claims and/or provide administrative services on behalf of the Policyholder Plan. Administrator in this definition does not have the same meaning as the term "Plan Administrator" used in the Employee Retirement Income Security Act of 1974 (ERISA), unless the Policyholder has specifically appointed their Administrator to perform as such.

**DISCLOSURE STATEMENT** means the disclosure statement(s) provided by the Policyholder to the Company in connection with the issuance or renewal of this Policy.

**EFFECTIVE DATE** means the date set forth on the cover page of the Policy.

**EXPERIMENTAL OR INVESTIGATIVE SERVICES** means medical treatments, procedures, technology, supplies or drugs which:

1. Have not been approved by the FDA for the particular condition at the time the service, medical treatment, procedure, technology, supply, or drug is provided; or
2. Are the subject of ongoing Phase I, II, or III Clinical Trial as defined by the National Institutes of Health, National Cancer Institute, or FDA, except for certain cancer drugs as outlined below; or
3. Have documentation published in U.S. peer-reviewed medical literature that states that further research, studies, or clinical trials are necessary to determine the safety, toxicity, or efficacy of the service, medical treatment, procedure, technology, supply, or drug; or
4. The patient has been asked to sign or has signed a release or other document indicating that the treatment is Experimental or Investigational or other term of similar meaning.

In determining any of the above, the Company will rely on recognized medical sources such as, but not limited to, the American Medical Association, including the Council of Technology Assistance Program and the Council on Medical Special Services; the National Institutes of Health; Medicare; the FDA; National Comprehensive Cancer Network, and other accepted medical authorities and sources.

In the context of drugs used in the treatment of cancer, the use of a drug will not be considered Experimental and/or Investigational where (1) the drug is not excluded under your Plan; and (2) the drug has been approved by the FDA; and (3) the use of the drug has been recognized as safe and effective for the treatment of the specific type of cancer in the National Comprehensive Cancer Network Drugs & Biologics Compendium™, Thomson Micromedex DRUGDEX, Thomson Micromedex DrugPoints, or Clinical Pharmacology; or (4) the drug is provided in association with a Phase III or IV Clinical Trial for cancer, as approved by the FDA or sanctioned by the National Cancer Institute.

Routine costs will not be considered Experimental and/or Investigational for Covered Persons accepted into an approved Clinical Trial (as defined by Section 2709(d) of the Public Health Services Act). Routine costs are limited to: (1) covered health services for which benefits are typically provided in the absence of a Clinical Trial; (2) covered health services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects or item of service, or the prevention of complications; and (3) covered health services needed for reasonable and necessary care arising for the provision of an investigational item or service.

Routine costs for a Clinical Trial does not include: (1) the investigational item, device, or service itself; (2) items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Covered Person; and (3) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis. As such, these items are considered Experimental or Investigational and are excluded.

**INCURRED** means the date on which the services are rendered or supplies are received by the Covered Person.

**ANNUAL MAXIMUM SPECIFIC BENEFIT** means the amount set forth on the Schedule of Insurance.

**LOSS** means expenses incurred by a Covered Person:

1. For which benefits are eligible and paid by the Policyholder under the Plan, and
2. Which are not in excess of the Usual and Customary Charge(s) for those services, and
3. Which are Medically Necessary and Appropriate for the treatment of an illness or injury or for any preventative care covered by the Plan, and
4. Which are reimbursable under this Policy subject to its terms, deductible(s), limitations and exclusions.

**MAXIMUM AGGREGATE BENEFIT PER BENEFIT PERIOD** means the maximum amount as specified in the Schedule of Insurance under the Aggregate Stop Loss benefit reimbursable by the Company to the Policyholder for the entire Policy Period as set forth in the Schedule of Insurance.

**MAXIMUM PLAN LOSSES PER COVERED PERSON PER BENEFIT PERIOD** means the maximum amount of losses which can be reimbursed under this Policy as set forth in the Schedule of Insurance.

**MEDICALLY NECESSARY AND APPROPRIATE** means for the purposes of determining benefits under this Policy, a Medically Necessary and Appropriate treatment is one that we determine meets all of the following criteria:

- It is recommended and provided by a licensed physician, dentist, or other medical practitioner who is practicing within the scope of their license; and
- It is generally accepted as the standard of medical practice and care for the diagnosis and treatment of the particular condition; and
- It is approved by the FDA, if applicable.

Such treatment, to be considered Medically Necessary and Appropriate, must be clinically appropriate in terms of type, frequency, extent, site, and duration for the diagnosis or treatment of the sickness or injury. The Medically Necessary and Appropriate setting and level of services is that setting and level of service which, considering the Covered Person's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary and Appropriate must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Covered Person's sickness or injury without adversely affecting the Covered Person's medical condition.

Merely because a physician recommends, approves or orders a treatment and/or service does not in and of itself make it Medically Necessary and Appropriate.

The Company retains the right to determine whether care or treatment is Medically Necessary and Appropriate. Medically Necessary and Appropriate determinations are made regardless of Provider Network agreement terms and conditions.

**MINIMUM ANNUAL AGGREGATE ATTACHMENT POINT** means the lowest amount of the Policyholder's responsibility for the Policy Period, as set forth in the Schedule of Insurance, for Losses under the Plan.

**MONTHLY AGGREGATE ATTACHMENT POINT** means the total number of Covered Units for that given Policy month multiplied by the corresponding Monthly Aggregate Factors, as specified in the Schedule of Insurance. However, in the event of a reduction in the number of Covered Units under the Plan, the Monthly Aggregate Attachment Point will not be reduced more than five percent from the preceding Monthly Aggregate Attachment Point.

**PAY, PAID, PAYMENT** means checks or drafts issued and deposited in the U.S. Mail or otherwise delivered to the payee, with sufficient funds on deposit on the date the check or draft is issued.

**PLAN** means the self-funded employee benefit plan adopted and issued by the Policyholder as required under ERISA. A copy of the Plan and any amendments in effect on the Policy Effective Date is on file with the Company and utilized for purposes of determining the Company's liability under this Policy. The Plan does not waive or modify any of the provisions of this Policy.

**POLICY PERIOD** means the specified period in the Schedule of Insurance, beginning no earlier than the Effective Date of the Policy and continuing until coverage terminates in accordance with the Policy Termination provision.

**POLICYHOLDER** means the legal entity, named on the face page, to which the Company has issued this Policy.

**SPECIAL LIMITATIONS** means a higher Specific Stop Loss Deductible for a specific Covered Person, or any reduction, exclusion from coverage, or other limitation of the reimbursement that would otherwise be made under the Policy with respect to a specific Covered Person(s) as shown in the Schedule of the Policy within the Special Limitations Provision.

**SPECIFIC DEDUCTIBLE** means the amount of the Policyholder's deductible for each Covered Person under the Plan during the Benefit Period as specified in the Schedule of Insurance. For each Covered Person, the Specific Deductible will apply separately to each Benefit Period.

**USUAL 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. Additionally, a charge must be reasonable for the services or treatments being provided and the service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

### **Aggregate Stop Loss**

If the Policyholder's Losses for the Benefit Period, stated in the Schedule of Insurance, exceed the Annual Aggregate Attachment Point for the Policy Period, the Company will reimburse the Policyholder, subject to the terms and conditions of this Policy, including the limits set forth in the Schedule of Insurance, an amount equal to:

- the Aggregate Percentage Reimbursable times the amount by which Losses exceed the Annual Aggregate Attachment Point; and
- not to exceed the Maximum Plan Losses per Covered Person per Benefit Period; and
- not to exceed the Maximum Aggregate Benefit per Benefit Period.

If this Policy terminates before the end of the Policy Period as stated in the Schedule of Insurance:

- the Annual Aggregate Attachment Point will be deemed not satisfied; and
- the Company will not be liable for any reimbursement under this Aggregate Stop Loss benefit.

After the end of the Benefit Period, the Company will reimburse the Policyholder for the Aggregate Stop Loss within a reasonable period of time, once satisfactory evidence of Payment of such Loss is received and approved by the Company.

While the determination of benefits under the Plan is the sole responsibility of the Policyholder, the Company reserves the right to interpret the terms and conditions of the Plan as they apply to this Policy. If Company finds that any Payment was not made in accordance with the terms of the Plan, or is not an eligible benefit under the Plan, the Company may exclude such Payment from Losses. The Company has the sole authority to approve or deny reimbursements under this Policy.

### **Specific Stop Loss**

If the Policyholder's Losses for the Benefit Period, as shown in the Schedule of Insurance, exceed the Specific Deductible, the Company will reimburse the Policyholder, subject to the terms and conditions of this Policy, including the limits in the Schedule of Insurance, an amount equal to:

- the Specific Percentage Reimbursable of Specific Stop Loss times the amount by which Losses exceed the Specific Deductible amount; but
- not to exceed the Annual Maximum Specific Benefit.

Losses for any Covered Person during the Policy Period will be determined according to the Benefit Period, as shown in the Schedule of Insurance.

The Specific Deductible amount as shown in the Schedule of Insurance applies separately to each Covered Person during a Benefit Period.

While the determination of benefits under the Plan is the sole responsibility of the Policyholder, the Company reserves the right to interpret the terms and conditions of the Plan as they apply to the Stop Loss Insurance Policy. If the Company finds that any Payment was not made in accordance with the terms of the Plan, or is not an eligible benefit under the Plan, the Company may exclude such Payment from Losses. The Company has the sole authority to approve or deny reimbursements under this Policy.

**Reimbursement of Certain Fees Under Specific Stop Loss:** The following fees will be included as eligible Losses for Specific Stop Loss when Incurred and Paid by the Policyholder, and approved by the Company:

1. Reasonable hourly fees, not to exceed \$135.00 per hour unless prior approval is received by Company, for case management services provided by a registered nurse case manager retained by the Policyholder or by the Designated TPA. Company retains the right to deny reimbursement of case management fees, if case management reports do not demonstrate quality case management services; and
2. Fees from a third party for: (a) hospital bill audits; (b) access to non-directed provider networks; and (c) negotiating out of network bills or negotiating additional discounts on in network bills. If the Policyholder can demonstrate a cost savings and submits a signed provider agreement, the Company will reimburse the Policyholder up to 25% of the amount saved, but not to exceed 75% of the amount paid to the provider up to a maximum of \$20,000. To determine the amount saved, the Company will compare the amount the Plan would have paid without the application of the savings against the amount that was paid because of the work performed.

The Company has the sole authority to approve or deny any payment of fees under this Policy.

Fees charged by the Designated TPA or any subsidiary, affiliate, related entity, or entity with shared common ownership for any of these services will be considered Losses only if prior approval has been obtained in writing from the Company.

## Exclusions

The Company will not reimburse any Loss or expense caused by or resulting from any of the following:

1. Legal expenses, court costs, or interest upon judgments.
2. Punitive or other damages assessed against the Policyholder, Designated TPA or other Party associated with the Plan.
3. Amounts Paid for administration of the Policyholder's Plan including, but not limited to, claim payment fees, cost containment administrative fees, PPO access fees, medical review and consultant fees, premium functions, unless otherwise covered under a provision within this Policy.
4. Amounts Paid for:
  - any individual who is not eligible for benefits under the Plan;
  - any services or supplies, rendered to a Covered Person, when such service or supply is not a covered service under the Plan.
5. Amounts Paid for Covered Persons which are in excess of Usual and Customary charges as determined by the Company.
6. Amounts Paid for expenses that are covered by any other medical plan or insurance, including amounts recoverable under any coordination of benefits provision.
7. Claims arising out of, caused by, contributed to, or in consequence of declared or undeclared war or act of war.
8. Amounts Paid for coverages provided by the employer, but not shown as covered in the Schedule of Insurance.
9. Claims arising out of or in the course of any occupation or employment for wage or profit or claims for which the Covered Person is entitled to benefits under any Workers Compensation or Occupational Disease Act or Law.
10. Any managed care discount, negotiated discount, audit savings, or other discount or savings forfeited or waived by the Policyholder for any reason, including, but not limited to, untimely payment.
11. Experimental or Investigative services, treatments, procedures technology, supplies, or drugs.
12. Amounts paid for care or service that is not Medically Necessary and Appropriate .
13. Amounts paid for Covered Persons who reside outside of the United States
14. Amounts paid for any treatment administered outside the United States if the Covered Person traveled to the location where the treatment was received for the purpose of obtaining treatment.
15. Regardless of any provision within the Plan, if on the Policy Effective Date or Policy Renewal Effective Date, a Covered Person is not actively at work or a dependent is totally disabled, in an institution receiving medical care or treatment, or confined at home or elsewhere, any expense incurred by the Covered Person will not be considered a covered expense under this Policy. This exclusion will continue for all expenses incurred by the Covered Person until he or she is actively at work or for a Dependent who is no longer totally disabled or is no longer in an institution receiving medical care or treatment or confined at home or elsewhere.

For the purposes of this exclusion, a Covered Person is considered to be actively at work if he or she is working at your usual place of business or at such places that your normal course of business may require; and performing all of the duties of his or her occupation on a full-time basis, and is not confined in any institution providing care or treatment of physical or mental infirmities.

If a Covered Person is not actively at work on the Policy Effective Date or Policy Renewal Effective Date solely because it was not a regularly scheduled work day, the Covered Person will be deemed to be actively at work on that day, provided the Covered Person is actively at work on the next regularly scheduled work day.

A Dependent is considered totally disabled if they, solely because of injury or sickness, cannot engage in substantially all of the normal activities of a person of like age and sex in good health.

Actively at work will not apply to those individuals previously disclosed and accepted by the Company.
16. Amounts Paid for Covered Persons: whose coverage extension under the Consolidated Omnibus Budget Reconciliation Act (COBRA) is continued beyond the timeframes specified by federal law for any reason, including clerical error of the Policyholder; who do not receive a valid COBRA extension offer within the

44 days immediately following a COBRA qualifying event; who fail to make a valid, signed COBRA election within the 60 days immediately following the receipt of COBRA election rights from the Policyholder; or who fail to remit COBRA premium within the period specified by federal law. The Company will require written documentation that these requirements have been satisfied.

17. Amounts paid for Covered Persons who are eligible for coverage under Medicare, any benefit reimbursable to the Policyholder under this Policy shall be reduced by the amount of any similar Medicare benefit paid or reimbursable so that the total reimbursements, with respect to a Covered Person or his or her dependents, shall not exceed 100% of such person's actual expenses.

### **Premiums and Factors**

**PAYMENT OF PREMIUMS:** No coverage under this Policy will be in effect until the first premium is paid. For coverage to remain in effect, each subsequent Payment as shown in the Schedule of Insurance for the applicable Policy Period, must be paid on or before its due date. The Policyholder is responsible for the Payment of its premiums. Premiums are not considered paid until the premium Payment is received by the Company.

**GRACE PERIOD:** A Grace Period of 31 days from the due date will be allowed for the Payment of each premium after the first premium Payment. During the Grace Period, the coverage will remain in effect, provided the premium is paid before the end of the Grace Period. If a premium otherwise due is not paid during the Grace Period, this Policy will be terminated without further notice, as of the date for which premiums were last paid.

**PREMIUM AMOUNT:** The Policyholder's premiums will be calculated using rates determined by the Company, as set forth in the Schedule of Insurance. The amount of total premium due is the sum obtained by multiplying each rate shown in the Schedule of Insurance by the Covered Units to which the rate applies. Any correction to the Specific or Aggregate premium of the Covered Units for the preceding Policy Period must be reported to the Company within sixty days after the last Policy month of the preceding Policy Period.

**PREMIUM RATE AND MONTHLY AGGREGATE FACTOR CHANGE:** The Company may change the Policyholder's premium rate or Monthly Aggregate Factor on any of the following:

- the date when the terms of this Policy are changed; or
- the date the Policyholder adds or deletes subsidiary or affiliated companies or divisions; or
- the date of any accepted revision to the Plan; or
- the date the geographic area in which the Policyholder has Employees or the nature of business in which the Policyholder is engaged in changes; or
- the date there is a change in enrollment exceeding 15% of the first month's enrollment of the current Policy Period or the 9<sup>th</sup> month of the prior Policy Period; or
- the date the Policyholder changes its Designated TPA; or
- the date the Policyholder changes the provider network it utilizes.

The Company reserves the right to recalculate the premium rate and the Monthly Aggregate Factor for the Policy Period, if there is more than a 15% variance between:

- the average monthly Paid claims under the Plan for the last two months of the prior Policy Period; and
- the average monthly Paid claims under the Plan for the first ten months of the prior Policy Period.

### **Policy Termination**

This Stop Loss Insurance Policy will continue in effect until the end of the Policy Period, unless coverage is terminated, as set forth below.

This Policy and all related benefits will terminate upon the earliest of the following dates:

- on the due date of any premium which is not paid, subject to the Grace Period; or
- the premium due date next following receipt by the Company of written notice from the Policyholder that this Policy is to be terminated; or
- the date of termination of the Plan; or
- the date the Policyholder suspends active business operations or is placed in bankruptcy or receivership; or
- the date the Policyholder dissolves.

This Policy may also be terminated at the Company's option immediately upon delivery of a written notification to the Policyholder, effective on:

- the date the number of Covered Persons under the Plan becomes less than 75% of those eligible;
- the date the Policyholder fails to perform any of its duties and obligations as set forth in this Policy;
- the date the Plan fails to pay claims promptly or to make funds available for the payment of claims as required by the Plan; or
- the date the Designated TPA or Network is changed by the Plan if notice is not provided to the Company and prior acceptance of the change obtained as required by the terms of this Policy.

If this Policy is terminated before the end of the Policy Period stated in the Schedule of Insurance, the Company has no obligation to reimburse the Policyholder for any Losses that are Paid after the date this Policy is terminated. The Company will not refund any portion of the premium paid by the Policyholder whose Plan terminated during the Policy Period.

**PLAN TERMINATION:** The Policyholder will immediately notify the Company in writing, if the Policyholder's Plan is terminated.

### **Claims Provisions**

**CLAIMS ELIGIBLE UNDER TWO POLICIES:** If a claim for reimbursement can be filed under two different Policy years, it must be filed under the earliest Policy year and is ineligible under the subsequent Policy or subsequent renewal.

**LIABILITY:** The Company will have neither the right nor the obligation under this Policy to directly pay any Covered Person, provider of professional or medical services, or other third party. The Company's sole liability is to the Policyholder, subject to the terms and conditions of this Policy. Nothing in this Policy shall be construed to permit a Covered Person to have a direct right of action against the Company. The Company will not be considered a party to the Plan or to any supplement or amendment to it. The Policyholder may not assign reimbursement under this Policy, and the Company will not recognize any such assignment.

**NOTICE OF CLAIMS:** The Policyholder must give written notice to the Company of a Covered Person receiving Eligible Services where the eligible paid claims are expected to exceed or have exceeded 50% of the Specific Deductible within 30 days (or as soon thereafter as reasonably possible) of the date incurred or the date the Policyholder becomes aware of the potential/actual claim. Written notice must include: Covered Person's first and last name, date of birth, identification number, claims paid and pending amount, primary diagnosis, date of onset, prognosis and anticipated liability for the Policy Period.

The Policyholder must report to the Company any Covered Person who is a potential/actual transplantation recipient (excluding corneal and cochlear transplants). Notification for potential/actual transplantation recipients must include the details provided above and the type of transplantation, donor type, date of evaluation, date of listing, facility name, and transplantation network contract provider name. The Policyholder must provide a minimum of quarterly updates to an initial notification or more frequently, if a salient change from the initial reported notice of claim has occurred or upon request of the Company.

The Policyholder must also give written notice of claims to the Company within 30 days of the date the Policyholder and their agents or other representatives become aware of the existence of facts which would reasonably suggest the possibility that Losses will be Incurred which are covered by this Policy, and which are subject to the Aggregate Stop Loss benefit and equal or exceed the Annual Aggregate Attachment Point or are expected to exceed that amount. In addition, the Policyholder must notify the Company immediately when it receives a claim for any potentially catastrophic loss as identified in Exhibit A.

**PAYMENT OF CLAIMS:** Amounts payable under this Policy will be paid to the Policyholder within a reasonable timeframe upon receipt, review and acceptance by the Company of Proof of Loss when the amount exceeds \$1000.00. Any reimburseable amount remaining unpaid at the end of the Policy Period will be paid after the end of the Policy Period.

**PROOF OF LOSS:** The Policyholder's written Proof of Loss must be submitted to the Company within 90 days of a claim Paid by the Policyholder. Later proof will be accepted only if it is shown to have been furnished as soon as reasonably possible and in no event later than one year after the date of Loss.

**RISK MANAGEMENT:** The Company has the right to retain the services of medical management vendors, at our expense, to assist us with cost containment when we anticipate that a Covered Person's eligible expenses will exceed 50% of the Specific Deductible or when a Covered Person's eligible expenses have exceeded the Specific Deductible during the Policy Year. We also may have a medical management vendor or other service provider contact you if, in our determination, that vendor provides a service that may allow your Plan to reduce costs and expenses.

**REPORTS AND AUDITS:** The Policyholder will submit by the 15<sup>th</sup> day of each month all Proof of Loss reports and supporting documents including, but not limited to, a monthly summary of all Losses Paid by the Policyholder and total number of Covered Units covered under the Plan during the prior month. The Policyholder will be responsible for the investigation, auditing, calculating, and the Payment of all claims under the Plan.

The Company will have the right:

- to inspect, copy, and audit all records and procedures of the Policyholder and Designated TPA developed and maintained for the Plan that are applicable to the administration of the Stop Loss Insurance Policy; and
- to require, upon request, documents, such as medical and eligibility records, case management notes, and other similar documents which are satisfactory to the Company that any Payment made to the Covered Person or the provider of such services or benefits were Paid in accordance with your Plan and for which are the basis for any purported Loss by the Policyholder.

The Policyholder and its Designated TPA must cooperate with the Company in the event the Company exercises its right to audit as set forth herein. The Company reserves the right to employ a third party to assist us with any audit function.

**RECOUPMENT:** We have the right to recoup from any claims payment any premium funds owed to the Company that have not been paid. Our right of recoupment does not impair our right to terminate this Policy for non-payment of premium under the termination provisions of this Policy.

**OFFSET:** Any payment or overpayment of a claim made to the Policyholder due to error or mistake must be promptly refunded to the Company upon notice to the Policyholder of such error or mistake. The Company may offset any funds owed to the Company against any funds due the Policyholder.

**RIGHT OF REIMBURSEMENT:** Amounts Paid which are reimbursed by, or payable by other insurance companies, reinsurers, or third parties will not be included in Aggregate Stop Loss or Specific Stop Loss benefits, nor can they be used to satisfy any Deductible under this Policy. Additionally:

- If the Company reimburses the Policyholder for amounts that are later recovered from another party, the amount recovered must be refunded by the Policyholder to the Company to the extent of any paid claims under this

Policy. Any repayment amount you owe us survives the termination of this Policy and recoveries made after this Policy terminates must be repaid to us.

- Should there be an over-reimbursement made to the Policyholder due to clerical or other error, the over-reimbursement must be refunded.
- If benefits for a Covered Person are payable under an extension of benefits provision of a previous insurance carrier, the Company will not accept responsibility for the expenses payable under the prior coverage for such individuals.

**SUBROGATION/RIGHT OF RECOVERY:** The Policyholder must pursue all valid claims including, but not limited to, claims for restitution, constructive trust, equitable lien, breach of contract, injunction, and any other state or federal law claims the Plan may have against any third party responsible, in whole or in part, for any Claims paid by the Plan. You must immediately advise us of any amount you recover from them. If the Policyholder fails to pursue any action against a third party and the Company has made benefit payments under this Policy, the Company 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 and required for the Company to pursue any action to recover against the third party; the scope of the Policyholder's cooperation shall include, without limitation, the execution of a Subrogation receipt or assignment in favor of the Company and the granting of authorization to the Company to commence litigation or other legal proceedings in the name of the Policyholder to seek recoveries from third parties. The Company agrees to pay its pro rata portion of the Policyholder's attorneys' fees or other costs associated with a claim or lawsuit to the extent that the Company recovers any portion of the benefits paid under this Policy pursuant to its Subrogation right.

### General Provisions

**ARBITRATION:** All disputes between the Policyholder and the Company shall be settled by arbitration in accordance with the Commercial Rules of the American Arbitration Association, except with regard to rules governing the selection of arbitrators. It is further stipulated that the arbitrator(s) shall, when adjudicating any dispute under this Policy, consider the terms and conditions of this Policy, applicable substantive law, and may, in the arbitrators' discretion, consider applicable custom and practice in the Accident and Health industry and the Employer Stop Loss sector. All matters shall be decided by a panel of three (3) arbitrators, all of whom must be either current or former officers or directors of Life, Health and Accident insurers or current or former insurance brokers or administrators with substantial experience in the Employer Stop Loss sector. Each party shall select its own party arbitrator and the parties' chosen arbitrators shall jointly select the third; in the event that the two party-arbitrators cannot agree on the third arbitrator, each party shall appoint three candidates, two of whom shall be stricken by the other party, and the third arbitrator shall thereafter be chosen from the remaining two candidates by the drawing of lots. Judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction.

This provision shall survive the termination or expiration of this Policy. The arbitrators shall have no power or authority to award punitive or exemplary damages. Any arbitration shall be confidential, and except as required by law, neither party may disclose the existence, content or results of any arbitration hereunder without the prior written consent of the other parties, except that disclosure is permitted to a party's auditors and legal advisors. The parties hereto may alter any of the terms of this provision only by express written agreement, although such alteration may be before or after any rights or obligations arise under this provision. This provision will survive the termination or expiration of this Policy.

**ASSIGNMENT:** Your interest in this Policy cannot be assigned.

**CLERICAL ERROR:** Clerical error in keeping any records pertaining to the coverage, whether by the Policyholder or by the Company, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated, provided such clerical error is not prejudicial to the Company and is rectified promptly upon discovery. Your failure to report the existence of a Covered Person or comply with the reporting requirements of this Policy shall not constitute clerical error.

**DESIGNATED THIRD PARTY ADMINSTRATOR:** Without waiving any rights under this Policy, and without making the Designated TPA a party to this Policy, we agree to recognize the Designated TPA as the administrator of the Policyholder's Plan(s), subject to the following:

- The Designated TPA is responsible on behalf of the Policyholder for auditing, calculating, and processing all claim expenses for the underlying Plan within a reasonable amount of time, preparing reports as required by us, and maintain and making available to us, at all times such information as we may reasonable require for proof of payment of claims.
- The Designated TPA must perform such other duties as may be reasonable required by us, including but not limited to, maintaining an accurate record of the Covered Persons under the Plan.
- We are not responsible for nor will this Policy reimburse any compensation or fees due to the Designated TPA for functions performed by them for the Policyholder in relation to this Policy.
- Notice to the Designated TPA by us under the provisions of this Policy will be considered notice to the Policyholder and notice to the Policyholder will be deemed notice to the Designated TPA.

**ENTIRE CONTRACT/CHANGES:** The entire contract between the Company and the Policyholder will consist of this Policy, the attached application and Disclosure Statement, any attached amendments or endorsements, and the Policyholder's Plan which is on file with the Company.

This Policy can be altered only with the consent of the Company and then only in writing. No such alteration of this Policy shall be valid unless endorsed on or attached to this Policy. No agent, broker, or Designated TPA has the authority to alter this Policy or to waive any of its provisions, including premiums shown in the Schedule of Insurance.

**INSOLVENCY:** The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder, The Plan or the Policyholder's Designated TPA will not impose upon the Company any liability other than the liability defined in this Policy. The insolvency of the Policyholder will not make the Company liable to the creditors of the Policyholder, including Covered Persons under the Plan.

**LEGAL ACTION:** No legal action may be brought against the Company until there has been full compliance with all the terms of this Policy. All Policy terms will be interpreted under the laws of the state shown on page 1 of this Policy. No legal action may be brought to recover on this Policy within 60 days after written Proof of Loss has been furnished. No legal action may be brought after two (2) years from the time written Proof of Loss is required to be furnished.

**MISREPRESENTATION, CONCEALMENT, FRAUD:** This entire Policy will be void and subject to rescission if the Company determines that the Policyholder or its agent has concealed or misrepresented any material fact or circumstance concerning this Policy, including without limitation material facts contained within the Policy application, the Disclosure Statement, any other material facts provided by the Policyholder to the Company prior to the Policy Effective Date, or regarding any claim or any case of fraud by the Policyholder or its Designated TPA or other agent relating to this Policy.

**MISSTATED DATA:** The Company has relied upon the underwriting information provided by the Policyholder, its Designated TPA, or other agent in the issuance of this Policy. Should subsequent information become known which, if known prior to issuance of this Policy, would have affected the rates, deductibles, terms, or conditions for coverage, the Company will have the right to revise the rates, deductibles, terms, or conditions as of the Effective Date of issuance, by providing written notice to the Policyholder or the Policyholder's agent. Nothing contained within this provision shall be deemed to in any way, affect the Company's right to rescind the Policy in the event of a material misrepresentation by the Policyholder or the Policyholder's agent.

**NON-PARTICIPATING POLICY:** This Policy is non-participating and does not share in the company's surplus earnings.

**NO ERISA LIABILITY:** Under no circumstance will the Company accept responsibility as a “Plan Administrator” or be deemed a “plan fiduciary” with respect to your Plan under the Employee Retirement Security Act of 1974, as amended.

**NOTICE:** For the purpose of any notice required from the Company under the provisions of this Policy, notice to the Designated TPA shall be considered notice to the Policyholder and notice to the Policyholder shall be considered notice to the Designated TPA. Notice from the Policyholder to the Designated TPA and notice from the Designated TPA to the Policyholder shall not be considered notice to the Company.

**NOTICE OF APPEAL OR LITIGATION:** The Policyholder must promptly provide the Company with written notice of any objection, appeal, or Insurance Department complaint received on a claim processed under the Plan on which it reasonably appears a reimbursement under this Policy may be payable. A copy of any document filed by or against the Policyholder in any court in connection with litigation under the Plan must be promptly furnished to the Company.

**OTHER COVERAGE:** The reimbursement provided by this Policy is in excess of other coverages such as group insurance, excess insurance, reinsurance, plan benefits including insurance or benefits established by any federal, state or local law.

**PARTIES TO THE POLICY:** The parties to this Policy are exclusively the Policyholder and the Company. The Company’s sole liability under this Policy is to the Policyholder. This Policy does not create any right or legal relation between the Company and a Covered Person under the Plan. This Policy will not be deemed to make the Company a party to any agreement between the Policyholder and any third party.

**PLAN:** The Policyholder will provide to the Company a complete copy of the Plan document governing the Plan. No Plan change will affect this Policy without the Company’s written consent. Written notice of the Plan change must be given to the Company at least 31 days prior to the effective date of the change. The Company will have the right to modify premium rates and/or other terms and conditions of coverage if the Company determines that its liability under this Policy has been affected by such Plan change. If advance written notice is not received and accepted and required herein, the Company’s reimbursement may be made as if the Plan had not been amended, at the Company’s discretion. The Company’s reimbursement will be made according to the amended Plan, once the notice is received and accepted.

**POLICY RENEWAL:** This Policy may be renewed unless it has been terminated or is subject to termination in accordance with the termination provisions of this Policy. Policy changes for any renewal Policy will appear on a revised Schedule of Benefits and/or a Policy amendment. Your payment of the renewal premium after receipt of the revised Schedule of Benefits and/or Policy amendment constitutes acceptance of the renewal Policy by you. At the end of the Policy Period, but only by mutual agreement of the Policyholder and the Company, this Policy may be renewed for another Policy Period. The renewal may be subject to new premium rates, new underwriting terms, a new Benefit Period and new Policy terms.

**RECORDS:** The Policyholder will maintain records of all Covered Persons under the Plan during the Policy Period and for a period of seven years after the termination of this Policy. The Policyholder shall make such records available to the Company as needed to evaluate its liability under this Policy.

**REINSTATEMENT:** If any premium that is due and owing to the Company is paid after the expiration of the Grace Period, the Company may at its option elect to reinstate the Policy on the terms and conditions that the Company elects at that time.

**SEVERABILITY:** In the event that a court of competent jurisdiction invalidates any provision of this Policy, all remaining provision of this Policy shall continue in full force and effect.

**STATE HEALTH CARE SURCHARGES:** If the Policyholder pays a state health care surcharge imposed by Louisiana, Massachusetts, or New York in connection with the payment of Losses, such health care surcharges are

included as Losses. We will only reimburse health care surcharges imposed by New York up to 9.63% of the amount upon which the surcharge was levied.

**TAXES:** In the event any state or federal taxing authority which has jurisdiction over either of the parties finds that additional taxes or other assessments, other than premium taxes paid by the Company with respect to this Policy, must be paid in respect of this Policy, the Plan, or related matters, the Policyholder shall be responsible for such additional taxes and the Company shall be held harmless from any such tax liability. Any payments made by the Company under this provision will be reimbursed by the Policyholder upon invoice. If payment is not received the Company reserves the right to offset any payments owed to the Policyholder until the tax is fully paid.

**TIME LIMIT ON CERTAIN DEFENSES:** In the absence of fraud, all statements made by the Policyholder shall be deemed representations and not warranties. No statement made by the Policyholder for the purpose of effecting insurance shall be used to contest this Policy or reduce benefits unless contained in a signed, written application, a copy of which has been provided to the Policyholder. No such statement will be used to contest this Policy after this Policy has been in force for two years.

**WAIVER:** Failure of the Company to strictly enforce its rights under this Policy at any time or under any circumstance shall not constitute a waiver of such rights by the Company at any time under the same or different circumstances.

## Exhibit A

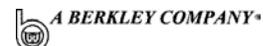
Claims which are considered to be potentially catastrophic are identified below:

1. Organ, tissue, or bone marrow transplants
2. A length of stay request of more than 14 days
3. A second request for extension of length of stay
4. A second admission in 6 months or less
5. Multiple system failure
6. Multiple trauma
7. Large dollar claim identified during the interim or final billing that exceeds \$15,000
8. Request for intensive level of home health care supplies or services
9. Request for transfer to a rehabilitation facility
10. Ventilator patient greater than 4 days
11. Pain medication required every 8 hours or more frequently
12. Hyperalimentation (total parenteral nutrition)
13. Interim hospital billing
14. Home IV antibiotic therapy
15. Malignant neoplasms (any site)
16. End stage renal disease
17. Biopsy of brain
18. Craniotomy
19. Lobectomy (lung)
20. Pneumonectomy
21. Laryngectomy
22. Thoracostomy
23. Esophagectomy
24. Gastrostomy
25. Hepatectomy
26. Pancreatectomy
27. Nephrectomy
28. Amputation
29. Major burns in excess of 20% - 30% of the body
30. HIV Positive or AIDS (Acquired Immune Deficiency Syndrome) Related Illnesses, such as:
  - Encephalopathy
  - Confusion in patients younger than 50 years old
  - Kaposi's sarcoma
  - Cytomegalovirus
  - Pneumocystis carinii pneumonia
  - Lymphoreticular malignancy

- Toxoplasmosis
  - Cryptosporidium
  - Isospora infection
  - Bronchial or Pulmonary Candidiasis
  - Progressive Multifocal Leukoencephalopathy
  - Herpes simplex or herpes zoster
31. Blood deficiency disorder
- Severe immune deficiency disorder
  - Aplastic anemia
32. Cardiovascular disease
- Endocarditis
  - Cardiomyopathy
  - Late effects of cardiovascular disease
33. Cerebral Vascular Disease with Neurological Deficits
- Anoxic brain damage
  - Multiple fractures, skull/face
  - Cerebral lacerations/ contusion
  - Intercranial or subarachnoid hemorrhage
  - Coma
  - Acute vascular disease (stroke, cardiovascular accident)
  - Viral encephalitis
34. High Risk Neonatal
- Congenital anomalies including but not limited to spina bifida, cleft lip or palate, anomalies of the heart, GI tract, limbs, or circulatory, respiratory, or nervous system
  - Intestinal malabsorption
  - Slow fetal growth, fetal malnutrition (failure to thrive)
  - Short gestation, low birth weight
  - Birth trauma
  - Intrauterine hypoxia and birth asphyxia
  - Respiratory distress syndrome
  - Other respiratory conditions
  - Fetal neonatal hemorrhage
  - Fetal hemolytic disease
  - Apnea/bradycardia
  - Hemorrhage (grade 2-4)
  - Broncho-pulmonary dysplasia
  - Hyaline membrane disease
35. High Risk Obstetrical
- Previous preterm delivery
  - Preterm labor – current pregnancy
  - Anomalous uterus, DES daughter, uterine surgery
  - Second trimester abortion (spontaneous or therapeutic)
  - Incompetent cervix, cone biopsy, large fibroids
  - Multiple gestation
  - Pyelonephritis, recurrent urinary tract infections
  - Cervical dilation or effacement prior to 36 weeks
  - Uterine irritability prior to 36 weeks
  - Placenta previa; polyhydramnios
  - Bleeding

- Toxemia
  - Premature rupture of membranes
  - Abruptio placenta
  - Request for home uterine monitoring, or home monitoring of pregnancy-induced hypertension
36. Infectious diseases
- Tuberculosis
  - Septicemia
  - Meningitis
  - Subacute bacterial endocarditis
  - Crohn's disease
  - Septic Arthritis
  - Osteomyelitis
37. Diabetes mellitus, complicated by one or all of the following:
- Circulatory disorders
  - Neurologic impairment
  - Amputation
  - Chronic renal failure
  - Blindness
  - Cardiac complications
38. Spinal injury/trauma and closed head injury
- Paralytic syndromes
  - Quadriplegia, paraplegia, or hemiplegia
  - Spinal cord injury
  - Closed head injury
39. Neuromuscular
- Amyotrophic Lateral Sclerosis
  - Myopathy
  - Guillain-Barre Syndrome
  - Cerebral Palsy
  - Multiple Sclerosis

# Berkley Life and Health Insurance Company



Urbandale, Iowa  
Underwriting Office:  
2445 Kuser Road, Suite 201  
Hamilton Square, NJ 08690

## Specific Simultaneous Funding Endorsement

This Endorsement revises and becomes a part of the Policy to which it is attached. This Endorsement is subject to all the provisions, limitations, and exclusions of the Policy, except as they are specifically modified herein. In the event any provision of the Policy and this Endorsement conflict, the terms of this Endorsement shall govern. Please read this Endorsement carefully.

This Endorsement attaches to and is made part of Policy Number ERL L16101095 001 issued to City of Carrollton.

### Specific Simultaneous Funding Benefit

After the Specific Deductible with regard to a Covered Person has been satisfied, the Company will, upon request, simultaneously fund Specific Stop Loss benefits for Plan claims that have been Incurred but not yet Paid by the Policyholder, subject to the following:

- Simultaneous funding is only available for Plan claims greater than \$1,000 over the Specific Deductible.
- Claims submitted for simultaneous funding must have been fully processed by the Policyholder or the Third Party Administrator according to the terms of the Plan and must be ready for Payment.
- Normal claim audit procedures will be implemented prior to any Specific Stop Loss benefits being paid by the Company.
- The Policyholder's Payment must be released to the providers of care within 10 working days of receiving the funding check by the Company. Payment within this time period will be considered a Paid claim within the Benefit Period. If such Payment is not made within the required time period, the funding check must be returned to the Company.
- Any portion of the funding check not used to Pay a Plan benefit, due to additional discounts or any other reason, must be returned to the Company within 10 days.

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

**EFFECTIVE DATE OF ENDORSEMENT:** 01/01/2016

Signed for the Company:

Handwritten signature of Christopher C. Brown in black ink.

President

Handwritten signature of Bv. Mc in black ink.

Secretary

## No New Special Limitations and Rate Cap Endorsement

This Endorsement revises and becomes a part of the Policy to which it is attached. This Endorsement is subject to all the provisions, limitations, and exclusions of the Policy, except as they are specifically modified herein. In the event any provision of the Policy and this Endorsement conflict, the terms of this Endorsement shall govern. Please read this Endorsement carefully.

This Endorsement attaches to and is made part of Policy Number ERL L16101095 001 issued to City of Carrollton.

**The Schedule of Insurance** in the Stop Loss Policy is amended as follows:

**The Specific Deductible section** is amended to include the following:

### No New Special Limitations at Renewal Program

It is hereby agreed and understood that the Specific Stop Loss Coverage will provide the following at the next renewal:

- There will be no new Special Limitations or increase on existing Special Limitations applied to the Specific Stop Loss coverage, provided that your Plan contains no benefit or eligibility changes.
- Existing Special Limitations remain as shown in the current Schedule of Insurance.

**The Premium section** is amended to include the following:

### Rate Cap at Renewal Program

Upon renewal, Specific premium rates are subject to a guaranteed maximum rate increase of 45%, provided:

- There are no changes to the Specific Benefit Period as shown in the Schedule of Insurance;
- There are no changes to the Specific Deductible as shown in the Schedule of Insurance;
- There are no changes to the commission level;
- There has not been more than a 15% increase or decrease in the number of Covered Persons as shown in the Schedule of Insurance;
- There has not been a change to Persons to Be Covered Under the Policy; and
- There is no significant change in the Benefits provided under your Plan or any significant change in the Plan terms.

We reserve the right to change, modify or cancel this Endorsement, should you amend or change your Plan in any way that materially affects our risk or liability with regards to the Policy or this Endorsement, or if your renewal Policy contains any of the material changes described above.

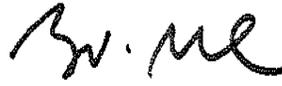
All other terms, conditions, limitations and exclusions of the Policy remain unchanged.

**EFFECTIVE DATE OF ENDORSEMENT:** 01/01/2016

Signed for the Company:

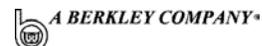
Handwritten signature of Christopher Brown in cursive script.

President

Handwritten signature of B.W. Mc in cursive script.

Secretary

# Berkley Life and Health Insurance Company



Urbandale, Iowa  
Underwriting Office:  
2445 Kuser Road, Suite 201  
Hamilton Square, NJ 08690

## Actively At Work Endorsement

This Endorsement revises and becomes a part of the Policy to which it is attached. This Endorsement is subject to all the provisions, limitations, and exclusions of the Policy, except as they are specifically modified herein. In the event any provision of the Policy and this Endorsement conflict, the terms of this Endorsement shall govern. Please read this Endorsement carefully.

This Endorsement attaches to and is made part of Policy Number ERL L16101095 001 issued to City of Carrollton.

### Actively at Work

The Actively at Work exclusion in the Policy is hereby deleted and replaced with the eligibility requirements of the Plan on file with Berkley Life and Health Insurance Company. Anyone not meeting the eligibility provisions of the Plan on file with Berkley Life and Health Insurance Company are excluded from coverage under the Stop Loss Policy to which this amendment is attached.

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

**EFFECTIVE DATE OF ENDORSEMENT:** 01/01/2016

Signed for the Company:

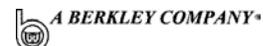
Handwritten signature of Christopher C. Brown in black ink.

President

Handwritten signature of B. W. Mc in black ink.

Secretary

# Berkley Life and Health Insurance Company



Urbandale, Iowa  
Underwriting Office:  
2445 Kuser Road, Suite 201  
Hamilton Square, NJ 08690

## External Appeal Endorsement

This Endorsement revises and becomes a part of the Policy to which it is attached. This Endorsement is subject to all the provisions, limitations, and exclusions of the Policy, except as they are specifically modified herein. In the event any provision of the Policy and this Endorsement conflict, the terms of this Endorsement shall govern. Please read this Endorsement carefully.

This Endorsement attaches to and is made part of Policy Number ERL L16101095 001 issued to City of Carrollton.

In the event Covered Services are Paid for a Covered Person due to a reversal by an Independent Review Organization of a previous denial of such Covered Services, and such Covered Services are Paid after the last Paid date provided in the Benefit Period (the "Last Paid Date"), the Benefit Period to pay such Covered expenses will be extended for a period not to exceed twelve (12) months from the Last Paid Date provided:

- a. Such Losses are not eligible under any other coverage; and
- b. Such Losses are otherwise payable under the terms of the Policy; and
- c. The Company was informed in writing with the details of the Loss within 60 days of the filing of an appeal for the claim denial.
- d. The Policy renews and is in effect when the claim is Paid.

When Losses are Paid pursuant to the terms and conditions of this Endorsement, such Losses will relate back to the Benefit Period in which they were Incurred and will be excluded from any other Benefit Period.

For purposes of this Endorsement, Independent Review Organization means the organization for external review as required under the external review process of the Patient Protection and Affordable Care Act and as covered under the Plan.

If the Policyholder terminates this Policy for any reason prior to the end of the Policy Period this Endorsement will be void.

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

**EFFECTIVE DATE OF ENDORSEMENT:** 01/01/2016

Signed for the Company:

Handwritten signature of Christopher Brown in cursive.

President

Handwritten signature of B. W. Mc in cursive.

Secretary

**BERKLEY LIFE AND HEALTH INSURANCE COMPANY  
PRIVACY NOTICE**

Berkley Life and Health Insurance Company (the "Company"), a member company of the W. R. Berkley Corporation ("Berkley") group of companies and each other member of the Berkley group of companies ("Affiliates") understands our customers' concern about privacy of their information collected by the Company. Our Company is dedicated to protecting the confidentiality and security of nonpublic personal information we collect about our customers in accordance with applicable laws and regulations. This notice refers to the Company by using the terms "us," "we," or "our." The law requires that we send you a notice describing our privacy policy and how we treat the nonpublic personal information about our customers that we receive in connection with our business (Information").

**Why We Collect and How We Use Information.**

We collect and use Information for business purposes with respect to our insurance products and services and other business relations involving our customers. We gather this Information to evaluate your request for insurance, to evaluate your insurance claims, to administer, maintain or review your insurance policy, and to process your insurance transactions. We also accumulate certain information about you as may be required or permitted by law.

Your insurance agent or broker also collects this Information and may use it to help with your overall insurance program or to market additional products and services to you. We may also use Information to offer you other products or services that we or our Affiliates provide.

**How We Collect Information.**

Most Information collected by us is provided by you or your insurance agent or broker to us. We obtain Information from (i) applications or other forms submitted by you, your insurance agent or broker or your authorized representatives to us and our Affiliates, and (ii) your transactions with us or our Affiliates. We may also obtain Information from other sources such as (i) consumer reporting agencies, (ii) other institutions or information services providers, (iii) employers, (iv) other insurers, or (v) your family members.

**Information We Disclose.**

We disclose any Information which we believe is necessary to conduct our business as permitted by applicable law or where required by applicable law. This disclosure may include (i) Information we receive from you on applications or other forms provided to us and our Affiliates, such as names, addresses, social security numbers, assets, employer information, salaries, etc. (ii) Information about your transactions with us and our Affiliates, such as policy coverages, premiums, payment history, etc., and (iii) Information we receive from a consumer reporting agency, such as credit worthiness and credit history.

**To Whom We Disclose Information.**

We may, as permitted or required by applicable law, disclose your Information to nonaffiliated third parties, such as (i) your insurance agent or broker, (ii) independent claims adjusters, (iii) insurance support organizations, (iv) processing companies, (v) actuarial organizations, (vi) law firms, (vii) other insurance companies involved in an insurance transaction with you, (viii) law enforcement, regulatory, or governmental agencies, (ix) courts or parties therein pursuant to a subpoena or court order, (x) businesses with whom we have a marketing agreement, or (xi) our Affiliates.

We may share Information with our Affiliates so that they may offer you products and services from the Berkley group of companies or to analyze our book of business and to consolidate necessary information. We do not disclose Information to other companies or organizations not affiliated with us for the purpose of using Information to sell their products or services to you. For example, we do not sell your name to unaffiliated mail order or direct marketing companies.

**How We Protect Information.**

We require our employees to protect the confidentiality of Information as required by applicable law. Access to Information by our employees is limited to administering, offering, servicing, processing or maintaining of our products and services. We also maintain physical, electronic and procedural safeguards designed to protect Information. When we share or provide Information to other persons or organizations, we contractually obligate them, if required by law, to treat Information as confidential and conform to our privacy policy and applicable laws and regulations.

**Correction and Access to Information.**

Upon our receipt of your written request to us at Berkley Life and Health Insurance Company, 475 Steamboat Road, Greenwich, Connecticut 06836-2519 we will, generally, make available Information for your review. If you believe the Information we have about you is incorrect or inaccurate, you may request that we make any necessary corrections, additions or deletions. If we agree with your belief, we will correct our records if required by applicable law. If we do not agree, you may submit to us a short statement of dispute, which we will include in any future disclosure by us of such Information if required by applicable law.

**Requirements for Privacy Notice.**

This privacy notice is being provided due to recently enacted federal and state laws and regulations establishing new privacy standards and requires us to provide this privacy policy. For additional information regarding our privacy policy, please write to us at 475 Steamboat Road, Greenwich, Connecticut 06836-2519.

Revised: February 7, 2006