AUTHORIZATION OF CHANGE IN SERVICES
CITY OF SAN MARCOS, TEXAS

PROJECT NAME:	Administrative Services Agreement
CITY PROJECT MANAGER/REP:	Stephanie Reyes, Assistant Director of Human Resources
CONSULTANT/VENDOR:	United HealthCare Services, Inc. Inc.
CONTRACT NO:	216-300
AUTHORIZATION NO:	2
CONTRACT EFFECTIVE DATE:	January 1, 2018
DATE OF THIS CHANGE:	November 21, 2017

WORK TO BE ADDED TO OR DELETED FROM SCOPE OF SERVICES

This Authorization of Change in Services amends the City's Administrative Services Agreement with United HealthCare Services, Inc. to add Stop Loss coverage for the 2018 employee medical plan year in accordance with the scope of work included as Attachment A.

Previous contract amount:	$3,078,337.00
Net increase/decrease in contract amount:	$ 483,000.00
Revised contract amount:	$3,561,337.00

United HealthCare Services, Inc.:

By:_____ Date:_____

_____
Printed name, title

Approved by:

City of San Marcos:

By:_____ Date:_____

_____
Printed name, title

City Department (PM, etc.) only below this line.

Account Number(s):_____, _____
Previous Changes in Service:
#_____; date; amount
#_____; date; amount
#_____; date; amount

Attachment A

UnitedHealthcare Stop Loss:

We offer individual stop loss (ISL) and aggregate stop loss (ASL) to help our self-funded customers manage cash flow and minimize their financial risk.

Our ISL policies protect the City of San Marcos from financial losses created by individual members who incur large claims under the benefit plan, and our ASL policies protect you from financial losses that result from the collective claim experience of all members covered under the benefit plan.

INDIVIDUAL STOP LOSS

ISL limits the City of San Marcos' liability on any one member in the benefit plan to an established limit (proposed - $150,000 per year) called the ISL level. When claims for any one member exceed the ISL level in one policy year, we reimburse you for the excess losses.

AGGREGATE STOP LOSS

ASL limits the City's liability on the collective claim experience of all members covered under the benefit plan to a predetermined threshold called an attachment point or trigger. We calculate the attachment point as a percentage of expected claims (proposed - 125 percent). When the collective claims for all members exceed the attachment point in one policy year, we reimburse you for the excess losses.

Key Advantages of UnitedHealthcare Stop Loss Insurance	
Immediate reimbursement	We automatically process stop loss claim reimbursements through your bank account. Our automated setup typically allows reimbursement to take place well before the claim payment draft is cashed, making reimbursement virtually immediate.
No reporting responsibilities for City of San Marcos	We automatically identify claims exceeding the stop loss limit, eliminating the need for you to submit stop loss claims for reimbursement. This also means no additional charges for special reports needed to interface with an outside stop loss vendor and no risk to you of incurring penalties for late reporting.
Administrative Simplicity	Stop loss premiums appear on the same bill as other UnitedHealthcare services and the stop loss renewal is presented at the same time as the medical renewal. One consolidated reporting package provides both stop loss and medical plan data. Additionally, there is no discrepancy in the definition of cashed, paid or incurred dates (such as date of admission or discharge) because the stop loss and underlying medical plan are both with UnitedHealthcare. To simplify the process even further, you can request coverage that eliminates differences between ISL and the underlying medical plan in defining outside limits, such as lifetime maximum benefits, and in defining inside limits by condition (mental health/chemical dependency or AIDS) or type of service (nursing care, etc.) since UnitedHealthcare covers both.

INCLUDED OPTION

MONTHLY ACCOMMODATION

We have included a monthly accommodation feature that reimburses you if aggregate claims exceed the pro rata year-to-date attachment point. Under the monthly accommodation method, your maximum cash outlay at any point during the policy year is limited to no more than the sum of the individual month's calculated obligations on a year-to-date basis. The monthly accommodation feature minimizes your monthly costs on a rolling basis.

ADDITIONAL OPTION (NOT INCLUDED)

TERMINAL LIABILITY COVERAGE

You have the option of purchasing terminal liability coverage at the original effective date or at any renewal. The coverage becomes effective 12 months after the purchase date. This coverage extends the accumulation of the last policy year for an additional three months (standard) or six months (optional). We must administer the run-out claims in order to provide terminal liability coverage. When you purchase terminal liability coverage:

- The ISL level and ASL attachment point remain the same as the mature final policy period during the run-out period.
- The accumulations continue the final policy period through the terminal period.
- We reimburse any excess claims that exceed the ISL level or ASL attachment point.
- We adjust the premium rates for the active period to include an amount of payment for this terminal protection during the active policy periods.

UnitedHealthcare

ASO ISL Pricing Comparison Exhibit

Customer Name:	**City of San Marcos**
Effective Date:	**1/1/2018**

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	Prior TML	Current 9 months	Current Annualized for comparison	Renewal No refund Endorse
Proposed Individual Stop Loss Level:	**$150,000**	**$150,000**	**$150,000**	**$150,000**
Individual Stop Loss Liability Limit:	**Unlimited**	**Unlimited**	**Unlimited**	**Unlimited**
ISL Total Quoted Subscribers:	**609**	**609**	**609**	**609**
Fixed Costs:				
Individual Stop Loss Rates PSPM:	**$54.61**	**$46.58**	**$62.10**	**$60.52**
Lasered Claimants	**Yes**	**Yes**	**Yes**	**Yes**
One @ additional $350K over spec (claims review end of September for possible renewal reduction); this laser is also on our current policy.				
Aggregate Stop Loss Rates PSPM	**$2.15**	**$2.88**	**$3.88**	**$5.34**
Proposed Individual Stop Loss Level:	**$150,000**	**$150,000**	**$150,000**	**$150,000**
Expected number of claimants over ISL deductible	**3**	**3**	**3**	**3**
Actual number of claimants over ISL deductible	**0**	**0**	**0**	**0**
		prem over 9 month term		
ISL Annual Premium at Proposed ISL Deductible	**$399,090**	**$340,407**	**$453,827**	**$442,280**
Aggregate Annual Premium	***$15,712.20***	***$21,047.04***	***$28,355.04***	***$39,024.72***
Total annual Stop Loss Premium	***$414,802.08***	***$361,453.68***	***$482,181.84***	***$481,304.88***
Premium Difference			**$120,728**	**$119,851**
% of annual change		*-12.86%*	***16.24%***	*-0.18%*
		Lower rate for 9 month term resulting for reduced risk for shorter coverage period.		
Amount subject to Reimburse at 25%		**$204,243.98**	**$272,296.08**	
Maximum Reimbursement		**51,061**	**68,074**	
Difference is fixed premium cost				**($877)**

UnitedHealthcare Insurance Company

A Stock Company

185 Asylum Street, Hartford, Connecticut

Phone: 1-860-702-5000

AMENDMENT NO. 1

Amendment to be attached to and made a part of Group Policy No. GA-908516AL, issued by UnitedHealthcare Insurance Company (herein called "Company") to City of San Marcos (herein called "Policyholder").

It is agreed by and between the Company and the Policyholder that

1. The page entitled "Schedule Of Benefits" as contained in the Policy is hereby replaced with the attached page entitled "Schedule Of Benefits".
2. This Amendment will hereby be effective as of January 1, 2018.

UnitedHealthcare Insurance Company

Jeffrey Alter, President

Thomas J. McGuire, Secretary

ACCEPTED BY: _____

Title: _____

Date: _____

UnitedHealthcare Insurance Company

A Stock Company

185 Asylum Street, Hartford, Connecticut

Phone: 1-860-702-5000

SCHEDULE OF BENEFITS

This Schedule of Benefits is only applicable to Excess Loss Insurance provided by the Company during the Policy Period shown below.

Policyholder: City of San Marcos

Policy Number: GA-908516AL

Effective Date: January 1, 2018

Administrator: United HealthCare Services, Inc.

Coverage specified herein is applicable only during the Policy Period from January 1, 2018 through December 31, 2018, and is further subject to all terms and conditions of this Policy.

SPECIFIC EXCESS LOSS INSURANCE

Benefit Period: Covered Expenses Incurred from April 1, 2017 through December 31, 2018 and Paid from January 1, 2018 through December 31, 2018.

Specific Deductible per Covered Person: $150,000

Specific Percentage Reimbursable: 100%

Maximum Specific Benefit per Covered Person: Unlimited

Specific Excess Loss Insurance includes:

- Medical
- Stand Alone Prescription Drug Program

Specific Excess Loss Premium: $60.52 per subscriber per month

AGGREGATE EXCESS LOSS INSURANCE

Benefit Period: Covered Expenses Incurred from April 1, 2017 through December 31, 2018 and Paid from January 1, 2018 through December 31, 2018.

Aggregate Excess Loss Insurance includes:

- Medical
- Stand Alone Prescription Drug Program

Aggregate Percentage Reimbursable: 100%

Maximum Aggregate Benefit: $1,000,000 per Policy Year

Minimum Annual Aggregate Deductible: $9,537,124 or 95% of the first Monthly Aggregate Deductible amount times 12, whichever is greater

Maximum Covered Expenses per Covered Person accumulating toward the Maximum Aggregate Benefit: $150,000

Monthly Aggregate Factors: $1,362.52 per subscriber

Aggregate Excess Loss Premium: $5.34 per subscriber per month

EXPERIENCE REFUND ENDORSEMENT

Policyholder: City of San Marcos

Effective Date: April 1, 2018

In consideration for the premium shown in the Schedule of Excess Loss, the Excess Loss Insurance Policy (the "Policy") will be revised with the addition of Experience Refund Provision.

EXPERIENCE REFUND

The Company will pay the Policyholder an Experience Refund of 25% of Net Profit if the Company issues the Policyholder a Policy/Amendment that provides insurance for a Subsequent Policy Period and insurance is continuous from the first day of the Policy Period through the entire Subsequent Policy Period.

NET PROFIT

Net Profit is calculated as:

a. 60% of the sum of all premiums paid by the Policyholder for the Specific Excess Loss Insurance for the Policy Period; minus

b. the sum of all Specific Excess Loss Insurance claims for the Policy Period.

CALCULATION OF REFUND

Company will calculate and send to the Policyholder, the Experience Refund, if due, 6 months after the end of the Policy Period. A premium credit in the amount of the Experience Refund will be applied to the next available bill.

If Specific Excess Loss Insurance claims are paid after an Experience Refund has been paid to the Policyholder, and such claims relate to the Policy Period for which the Experience Refund has been paid a new Net Profit will be calculated and the Policyholder shall reimburse Company for any reduction in the Experience Refund within thirty (30) days after written notice by the Company. Company may, at its option be reimbursed for any reduction on a previously paid Experience Refund by subtracting the reduced amount from any future payable claim.

All other provisions of the Excess Loss Insurance Policy remain unaffected by this Endorsement.

Jeffrey Alter, President

Thomas J. McGuire, Secretary

UnitedHealthcare Insurance Company

STOP LOSS POLICY

FOR

City of San Marcos

Policy Number: GA-908516AL

Effective Date: April 1, 2017

State or other Jurisdiction of Issue: Texas

UNITEDHEALTHCARE INSURANCE COMPANY

A Stock Company

185 Asylum Street, Hartford, Connecticut

Phone: 1-860-702-5000

UnitedHealthcare Insurance Company ("Company") agrees to reimburse the Policyholder as outlined under the provisions of this Excess Loss Insurance Policy ("Policy").

This Policy is legally binding between the Policyholder and UnitedHealthcare Insurance Company. The consideration for this Policy includes, but is not limited to, the Application and the Payment of premiums as provided hereinafter.

The Policyholder is entitled to the reimbursement described in this Policy if the Policyholder is eligible for insurance under the provisions of this Policy. Reimbursement is subject to the terms and conditions of this Policy.

The first premium is due on the first (1st) day of the Policy Period. Subsequent monthly premiums are due on the first (1st) day of each month thereafter. The premium is not considered Paid until the Company receives the premium payment.

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

This Policy is delivered in and is governed by the laws of the state of issue.

IN WITNESS WHEREOF UnitedHealthcare Insurance Company has caused this Policy to be executed by its President and Secretary.

Jeffrey Alter, President

Thomas J. McGuire, Secretary

EXCESS LOSS INSURANCE POLICY

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call UnitedHealthcare's toll free telephone number for information or to make a complaint at:

1-800- 454- 0233

You may also write to UnitedHealthcare Insurance Company at:

UnitedHealthcare Insurance Company
P.O. Box 19032
Green Bay, WI 54307-9032

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 at:

P .O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Web: 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.

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de UnitedHealthcare's para obtener información o para presentar una queja al:

1-800- 454-0233

Usted también puede escribir al UnitedHealthcare Insurance Company a:

UnitedHealthcare Insurance Company
P.O. Box 19032
Green Bay, WI 54307-9032

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al:

1-800- 252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P .O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Sitio web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:

Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con (el agente) (la compañía) (el agente o la compañía) primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU PÓLIZA:
Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

DEFINITIONS

ADMINISTRATOR means a firm or person who has been retained by the Policyholder to provide administrative services on behalf of the Policyholder/Plan.

ANNUAL AGGREGATE DEDUCTIBLE for any one Policy Period means the greater of: (a) sum of the Monthly Aggregate Deductibles; or (b) the Minimum Annual Aggregate Deductible.

BENEFIT PERIOD means the period of time specified in the Schedule of Benefits in which a Covered Expense 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 this Policy's eligibility requirements.

COVERED EXPENSE means medical or other expenses under the Plan to which this Policy applies, as shown in the Schedule of Benefits, and which are not specifically excluded by the terms of this Policy. Covered Expense does not include any payment for the cost of administrating the Plan or other Policyholder contracted services.

COVERED PERSON(S) means each person covered under the Plan.

COVERED UNITS(S) means the types of Covered Units and the factors and premium rates for each type as shown in the Schedule of Benefits.

EFFECTIVE DATE is the date set forth in the applicable Schedule of Benefits.

INCURRED means with respect to medical services or supplies, the date on which the services are rendered or supplies are purchased by the Covered Person.

MONTHLY AGGREGATE DEDUCTIBLE means, with respect to a particular month, the total number of Covered Units for that given Policy month multiplied by the corresponding Monthly Aggregate Factors as specified in the Schedule of Benefits.

PAY, PAID, PAYMENT means under the Specific Excess Loss, on the date the Policyholder's check of Payment of a Plan benefit is issued by the Administrator or when a credit of funds for Payment of a Plan benefit has been debited by the Policyholder's bank account. Under the Aggregate Excess Loss, on the date the Policyholder's check for Payment of a Plan benefit has been presented through the collecting bank and reported to the Administrator or when a credit of funds for Payment of a Plan benefit has been debited by the Policyholder's bank account.

PLAN means the self-funded health care plan established by the plan sponsor to provide certain benefits to Covered Persons.

PLAN DOCUMENT means the written document approved by the Policyholder. A copy of the Plan Document in effect on the Effective Date is attached to the application for Excess Loss Insurance.

POLICY PERIOD means the specified period in the Schedule of Benefits, however beginning no earlier than the Effective Date of this Policy and continuing until coverage terminates in accordance with the Termination Provisions.

SPECIFIC DEDUCTIBLE is set forth in the Schedule of Benefits. The Specific Deductible will apply separately to each Benefit Period.

REIMBURSEMENT PROVISIONS

NOTICE OF COVERED EXPENSE The Policyholder authorizes the Administrator to file claims on its behalf under this Policy. The Policyholder authorizes the Company to reimburse Covered Expenses to the Administrator for deposit into the bank account maintained by the Policyholder for the funding of benefits under the Plan.

PAYMENT BY PLAN 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 Document as it applies to this Policy. The Company will have the sole authority to reimburse or deny reimbursement under this Policy.

SPECIFIC EXCESS LOSS INSURANCE

The Schedule of Benefits indicates whether Specific Excess Loss Insurance is provided under this Policy. If, while this Policy is in effect, the Covered Expenses for a Covered Person for the applicable Benefit Period exceed the Specific Deductible, the Company will reimburse the Policyholder, subject to the terms and conditions of this Policy including the limits set forth in the Schedule of Benefits.

The amount of the reimbursement will be equal to the Specific Percentage Reimbursable times the amount by which Covered Expenses exceed the Specific Deductible amount, but will not exceed the Maximum Specific Benefit. For purposes of determining whether such Maximum Specific Benefit has been exceeded, Covered Expenses Incurred or Paid in any other Policy Period under this policy are included.

Covered Expenses for any Covered Person during the Policy Period will be determined according to the Benefit Period described in the Schedule of Benefits.

If Specific Excess Loss Insurance terminates before the end of the Policy Period, the Specific Deductible will not be reduced.

AGGREGATE EXCESS LOSS INSURANCE

The Schedule of Benefits indicates whether Aggregate Excess Loss Insurance is provided under this Policy. If the Covered Expenses for the applicable Benefit Period exceed the Annual Aggregate Deductible 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 Benefits.

The amount of the reimbursement will be equal to the Aggregate Percentage Reimbursable times the amount by which Covered Expenses exceed the Annual Aggregate Deductible amount, but will not exceed the Maximum Aggregate Benefit.

Covered Expenses will not include any amounts reimbursed by the Company under any other provision of this Policy. If the Policyholder's coverage terminates before the end of the Policy Period, the greater of the Accumulated Annual Aggregate Deductible or the Minimum Annual Aggregate Deductible will apply. The Minimum Aggregate Deductible will not be reduced.

PREMIUMS AND FACTORS PROVISIONS

PAYMENT OF PREMIUMS For coverage to remain in effect, any subsequent monthly premium must be received by the Company by the first (1st) day of each month. Premiums are not considered Paid until the Company receives the premium payment. Premiums or other payments made by the Policyholder to their Administrator or Agent or Broker shall not be deemed or considered payments to the Company until actually received by the Company. The entire amount of the applicable premium shall be paid when due. The Company 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.

A late payment charge may be assessed for any premiums not received within thirty-one (31) calendar days following the due date. A service charge will be assessed for any non-sufficient-fund check received in payment of premiums. The Policyholder will reimburse the Company for any attorney's fees and any other costs related to collecting delinquent premiums.

GRACE PERIOD A Grace Period of thirty-one (31) days from the due date will be allowed for the payment of each premium after the first. During the Grace Period, the coverage will remain in effect provided the full premium is Paid before the end of the Grace Period. Should a premium otherwise due, not be Paid during the Grace Period, this Policy will terminate without further notice as of midnight on the last day for which premiums were Paid.

PREMIUM AMOUNT The premiums will be calculated using rates determined by the Company as set forth in the Schedule of Benefits. The amount of total premium due each month is the sum obtained by multiplying the applicable premium rates shown in the Schedule of Benefits by the actual number of appropriate Covered Units.

The Policyholder will be liable for any premium taxes assessed at any time against the Company beyond any taxes which may be payable on the premium received by the Company.

All requests for adjustments, credits or refunds because of overpayment of premiums shall be reported, in writing, with accompanying detail within sixty (60) days after termination of the applicable Policy Period.

The Company will not refund any portion of the premiums Paid if this Policy terminates during this Policy Period. The Company shall be entitled to reduce the reimbursements due the Policyholder under this Policy against any premiums due and unpaid, any overpayments or other reimbursements made in error or upon incorrect information, and any other amounts due the Company.

PREMIUM RATE AND MONTHLY AGGREGATE FACTOR CHANGE The Company may change the Policyholder's premium rates or factors for any of the following:

a) the date when the terms of this Policy are changed;

b) the date the Plan Document changes are accepted by the Company;

c) the date the Policyholder adds or deletes subsidiary or affiliated companies or divisions;

d) the date the number of Covered Units on any premium due date varies more than ten percent (10%) from the number of Covered Units as of the first month of the Policy Period.

TERMINATION PROVISIONS

This Policy and coverage provided hereunder will terminate upon the earliest of:

a) the premium due date of any premium which remains unpaid at the end of the Grace Period;

b) the premium due date next following receipt by the Company of written notice from the Policyholder that this Policy is to be terminated;

c) the date of termination of the Plan;

d) the date the Policyholder suspends active business operations or dissolves;

e) the end of the Policy Period; or

f) the date the administrative services agreement with the Administrator is terminated.

This Policy may also be terminated, at the Company's option on the earliest of:

a) the last day of the second (2nd) consecutive month during which there are less than twenty-five (25) employees enrolled in the Plan, unless the Company agrees, in writing, to continue coverage; or

b) the date the Policyholder fails to comply with the terms of this Policy; or

c) on the Policy anniversary date by the Company giving sixty (60) days advance written notice that this Policy will end, or such other notice as required by law.

The Company will not refund any portion of the premiums paid if this Policy is terminated during the Policy Period.

SUBSEQUENT POLICY PERIOD PROVISIONS

At the end of a Policy Period, this Policy may have a Subsequent Policy Period only by mutual agreement of the Policyholder and the Company and provided that the Company has not given a thirty (30) day termination notice or such other termination notice as required by law. The Subsequent Policy Period may be subject to new premium rates, factors, new underwriting terms, new Benefit Period and other new Policy terms. The terms and conditions for a subsequent Policy Period will be evidenced by the issuance of a new Schedule of Benefits by the Company, which shows the new premium rates, Benefit Period and other new terms.

GENERAL PROVISIONS

ADMINISTRATOR The Policyholder may retain an Administrator to act as an agent for the Policyholder in performing any or all of the duties as designated by the Policyholder. Without waiving any of its rights under this Policy, and without making the designated Administrator a party to this Policy, the Company agrees to recognize the Administrator as an agent of the Policyholder. The Policyholder will immediately notify the Company in writing if the agreement between the Policyholder and the Administrator terminates.

ASSIGNMENT The Policyholder may not assign the Policyholder's interest in or reimbursement under this Policy, and the Company will not recognize any such assignment.

AUDITS The Company will have the right: (a) to inspect and audit all records and procedures of the Policyholder and Administrator, developed and maintained for the Plan, that are applicable to the administration of this Policy; and (b) to require, upon request, proof satisfactory to the Company that Payment has been made to the Covered Person or the provider of such services or benefits which are the basis for any Loss by the Policyholder hereunder.

CHANGES TO THE PLAN DOCUMENT If the Plan Document in effect on the Effective Date is subsequently amended, notice of the amendment will be given to the Company prior to the effective date of the change. If the Company does not give written acceptance of the amendment, the Company will only provide coverage under this Policy consistent with the Plan Document prior to amendment. The Company's reimbursement will be made according to the amended Plan, once the notice is received and accepted.

CHANGES TO THE POLICY Only the President, a Vice President, or the Secretary of the Company have the authority to alter this Policy, or to waive any of the Company's rights and then only in writing. No such alteration of this Policy shall be valid unless endorsed and attached to this Policy. No agent, broker, or Administrator has the authority to alter this Policy or to waive any of its provisions.

CLERICAL ERROR Clerical errors, whether by the Policyholder or by the Company, in keeping or transmitting any records pertaining to the coverage, will not invalidate or limit coverage otherwise validly in force nor continue coverage otherwise validly terminated. Clerical error does not include any failure of the Policyholder, the Administrator or any agent of the Policyholder: (a) to comply with the requirements relating to notice of claims or payment of claims; or (b) to disclose underwriting information requested by the Company, whether or not intentional and regardless of the actual knowledge of the person providing the information.

CONFORMITY WITH LAW 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.

ENTIRE CONTRACT The Entire Contract between the Company and the Policyholder will consist of this Policy, Schedule of Benefits, application, approved amendments or endorsements, and a copy of the Plan Document, which is on file with the Company.

INSOLVENCY Nothing in this Policy shall either relieve an insolvent or bankrupt Policyholder from the obligation to pay premiums when due or delay or abate cancellation of this Policy for failure to do so. The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder or the Policyholder's Administrator will not impose upon the Company any liability other than the liability defined in this Policy. In particular, 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 The Policyholder cannot file suit until ninety (90) days after the date on which proof of loss is given to the Company. The Policyholder cannot file suit more than three (3) years after the date on which the Policyholder must give the Company proof of Loss.

LIABILITY The Company will have neither the right nor the obligation under this Policy to directly pay any Covered Person or provider of professional or medical services. 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 of the Policyholder, or to any supplement or amendment to it.

MISSTATED DATA, CONCEALMENT, FRAUD The Company has relied on the information provided by the Policyholder, the Administrator or any agent of the Policyholder, in the issuance of this Policy, or for any Subsequent Policy Period. In the event of a misrepresentation, concealment or omission of a fact, or a mistake of fact (whether or not a mutual mistake), any of which materially affect the underwriting, premium, rating or terms and conditions of this Policy, the Company may, at its option:

(a) increase premium rates, attachment points and/or otherwise change the terms and conditions of this Policy. Such increase or change to be effective retroactively to the Effective Date or as of any premium due date thereafter, or

(b) terminate this Policy as of the next premium due date.

The Company may declare this Policy null and void in its inception if, whether before or after a claim, the Policyholder, Administrator or any agent of the Policyholder has willfully or intentionally misrepresented, concealed, omitted any material fact affecting terms, conditions, or underwriting of this Policy. In such event, the Company's liability under this Policy shall be limited to refunding premiums paid by the Policyholder after deducting therefrom the amount of any Covered Expenses reimbursed by the Company to the Policyholder prior to the date of termination. If the amount of the Covered Expenses reimbursed by the Company to the Policyholder exceeds the premiums paid by the Policyholder, the Policyholder shall pay the Company the difference within thirty (30) days of the date the Company notifies the Policyholder of such difference.

NOTICE OF COMPLAINT, APPEAL, LEGAL ACTION As a condition precedent to the Company reimbursing the Policyholder in any settlement or judgment for a disputed Covered Expense, the Policyholder shall immediately inform the Company of any notice of appeal, notice of legal action, or objection, demand or complaint which the Policyholder received regarding any Covered Expense that may be reimburse under this Policy.

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

PARTIES TO THE POLICY The parties to this Policy are 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 the Administrator.

POLICYHOLDER REQUIREMENTS The Policyholder agrees to provide funds for Payment of all eligible expenses under the Plan. If the Policyholder fails to provide funds for timely Payment: (a) coverage under this Policy will immediately terminate; and (b) any Aggregate and/or Specific Deductible will be deemed not satisfied.

RECORDS The Policyholder will maintain records of all Covered Persons under the Plan during the Policy Period and for a period of seven (7) years after the end of the Policy Period. The Policyholder will make all such records available to the Company as needed to evaluate its liability under this Policy.

The Policyholder will maintain a separate record of any and all amounts Paid in excess of benefits eligible under the Plan.

SEVERABILITY CLAUSE Any clause deemed void, invalid, or otherwise unenforceable, whether or not such a provision is contrary to public policy, will not render any of the remaining provisions of this Policy invalid.

TERMINATION OF THE POLICYHOLDER'S PLAN The Policyholder will immediately notify the Company, if the Plan is terminated.

THIRD PARTY RECOVERY The Policyholder shall cause the Plan to undertake to pursue any and all valid claims the Plan or a Covered Person may have against third parties arising out of any occurrence resulting in a payment by the Plan or reimbursement by the Company. The Policyholder will account for and pay to the Company any amounts recovered which are reimbursable by the Company to the Policyholder under this Policy, regardless of whether this Policy is still in force on the date of recovery. Third party shall mean a person, entity or insurance company other than the Plan, the Policyholder or a Covered Person. An insurance company shall include insurance companies providing third party liability coverage, or other insurance coverage; i.e. no fault, uninsured, under insured or other similar coverage.

The Policyholder or Administrator shall notify the Company immediately upon discovering that a claim against a third party may exist. Should the Policyholder or the Administrator fail to pursue any valid claims against a third party, the Policyholder shall cause the Plan to assign its subrogation and third party recovery rights to the Company so as to allow the Company to pursue third party recoveries for Covered Expenses reimbursable to the Policyholder. In the event of such assignment, the Company shall have to exercise and enforce all of the Policyholders and/or Plan's rights against such third party. The Policyholder shall furnish such information, assistance, cooperation and execute and deliver such instruments, all as are necessary for the Company to pursue third party recoveries pursuant to this provision.

The Company's right to third party recoveries, as provided for in this provision, shall constitute and impose a trust and first-priority lien arising from any cause of action, settlement, judgment or arbitration award against a third party.

The Policyholder shall pay the Company all amounts recovered, whether by suit, settlement, alternative dispute resolution, including but not limited to arbitration or mediation, or otherwise, from any third party or their insurer to the extent of Covered Expenses regardless of whether such recovery shall be a full or partial recovery. If a third party recovery received by the Plan or Policyholder is less than the total amount paid by the Plan on behalf of the Covered Person, the Company shall be entitled to recover first, in full, any Covered Expense reimbursed by the Company under this Policy. The Company's recovery shall not be reduced by any attorney's fees incurred by the Policyholder, Plan or Covered Person unless the Company otherwise agrees in writing. All remaining amounts shall be paid to the Policyholder.

The Policyholder's failure to comply with this provision may result in the denial of a Covered Expense, in addition to all other rights of the Company under this Policy.

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

GENERAL EXCLUSIONS PROVISIONS

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

(a) Any payment which does not strictly comply with the terms and conditions of the Plan Document;

(b) Any payment or expense caused by or resulting from war, declared or undeclared or international armed conflict;

(c) Any payment for litigation costs and expenses, extra-contractual damages, compensatory damages, interest, 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, Plan, Administrator or any agent or representative of the Policyholder, Plan or Administrator;

(d) Any payment for occupational accidents or illnesses which are also eligible expenses covered by Workers' Compensation or Occupational Disease law, or similar legislation, whether or not coverage under such law is actually in force.

EXPERIENCE REFUND ENDORSEMENT

Policyholder: City of San Marcos

Effective Date: April 1, 2017

In consideration for the premium shown in the Schedule of Excess Loss, the Excess Loss Insurance Policy (the "Policy") will be revised with the addition of Experience Refund Provision.

EXPERIENCE REFUND

The Company will pay the Policyholder an Experience Refund of 25% of Net Profit if the Company issues the Policyholder a Policy/Amendment that provides insurance for a Subsequent Policy Period and insurance is continuous from the first day of the Policy Period through the entire Subsequent Policy Period.

NET PROFIT

Net Profit is calculated as:

a. 60% of the sum of all premiums paid by the Policyholder for the Specific Excess Loss Insurance for the Policy Period; minus

b. the sum of all Specific Excess Loss Insurance claims for the Policy Period.

CALCULATION OF REFUND

Company will calculate and send to the Policyholder, the Experience Refund, if due, 6 months after the end of the Policy Period. A premium credit in the amount of the Experience Refund will be applied to the next available bill.

If Specific Excess Loss Insurance claims are paid after an Experience Refund has been paid to the Policyholder, and such claims relate to the Policy Period for which the Experience Refund has been paid a new Net Profit will be calculated and the Policyholder shall reimburse Company for any reduction in the Experience Refund within thirty (30) days after written notice by the Company. Company may, at its option be reimbursed for any reduction on a previously paid Experience Refund by subtracting the reduced amount from any future payable claim.

All other provisions of the Excess Loss Insurance Policy remain unaffected by this Endorsement.

Jeffrey Alter, President

Thomas J. McGuire, Secretary