HM LIFE INSURANCE COMPANY

FIFTH AVENUE PLACE, 120 FIFTH AVENUE, PITTSBURGH, PA 15222-3099

1-800-328-5433

POLICY NUMBER	407517-B
POLICYHOLDER	City of Mesquite
TYPE OF COVERAGE	Stop Loss Insurance
EFFECTIVE DATE	January 01, 2022
POLICY TERM	January 01, 2022 through December 31, 2022
POLICY ISSUED IN	Texas

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

HM Life Insurance Company agrees to pay the benefits provided by this Policy, in accordance with the provisions of this Policy.

The consideration for this Policy is the application of the Policyholder and the payment by the Policyholder of premiums as provided herein.

This Policy provides benefits to the Policyholder when Eligible Claims Expenses, which are Paid by the Policyholder through the Covered Underlying Plan(s), exceed the levels defined in this Policy. The benefits of this Policy and the terms and conditions that apply to this Policy are explained herein.

The Effective Date of this Policy is 12:01 AM Eastern Time on the first day of the Policy Term and the expiration date of this Policy is 11:59 PM Eastern Time on the last day of the Policy Term.

This Policy may be renewed for subsequent Policy Terms in accordance with the renewal terms outlined in this Policy. If this Policy is renewed the terms and conditions of this Policy may be revised.

This Policy is governed by the laws of the jurisdiction in which it is issued and will be administered in accordance with such laws.

All provisions on this and the following pages are a part of the Policy.

HM Life Insurance Company

By

President

This Policy is Non-Participating

Have a complaint or need help?

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

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

HM Life Insurance Company

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

Call: Compliance Department Complaint Coordinator at 1-800-328-5433

Toll-free: 1-800-328-5433

Email: HMIGComplaints@highmark.com

Mail: 120 Fifth Avenue, Suite PAP HM-063A, Pittsburgh, PA 15222

The Texas Department of Insurance

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

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

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

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

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

HM Life Insurance Company

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

Call: Compliance Department Complaint Coordinator at 1-800-328-5433

Toll-free: 1-800-328-5433

Email: HMIGComplaints@highmark.com

Mail: 120 Fifth Avenue, Suite PAP HM-063A, Pittsburgh, PA 15222

El Departamento de Seguros de Texas

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

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

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

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

TEXAS DISCLOSURE OF GUARANTY FUND NONPARTICIPATION

In the event the insurer is unable to fulfill its contractual obligation under this policy, the contract-holder is not protected by an insurance guaranty fund or other solvency protection arrangement.

Table of Contents

Part 1. DECLARATION PAGE

A. POLICY INFORMATION

1.	Policy Number	407517-B
2.	Policyholder	City of Mesquite
3.	Policy Term	January 01, 2022 through December 31, 2022
4.	Covered Underlying Plan(s)	City of Mesquite Health Plan
5.	Claims Administrator(s)	Blue Cross Blue Shield of Texas
6.	Pharmacy Benefit Manager(s)	Blue Cross Blue Shield of Texas

B. SPECIFIC BENEFIT SCHEDULE

For all Eligible Claims Expenses except those to which a Special Risk Limitation applies:

1. Covered Claims Basis:

   Eligible Claims Expenses Incurred from January 01, 2020 through December 31, 2022 and Paid from January 01, 2022 through December 31, 2022.

2. Specific Eligible Claims Expenses include:

Medical	Yes
Prescription Drug Card	Yes

3. Number of Covered Units:

Composite	1,133

4. Specific Deductible

Per Participant	$400,000

5. Specific Payable Percentage: 100%

6. Maximum Specific Benefit in excess of the Specific Deductible per Participant

Per Lifetime	Unlimited

C. PREMIUM

Specific Premium Rate per Policy Month per Covered Unit:

Composite:	$67.54

The Specific Premium Rate per Policy Month only applies to this Policy Term.

D. SPECIAL RISK LIMITATIONS

Disabled/Hospital Confined, actively at work, activity of daily living, out-of-hospital, or similar requirements waived with Disclosure:	Yes
Retirees Included:	Yes

E. AFFILIATES

None

Part 2. DEFINITIONS

The definitions of terms apply whenever the terms are used anywhere in this Policy. "We", "us", and "our" refer to HM Life Insurance Company. Other defined terms are printed with an initial capital letter.

AFFILIATE means a company subsidiary to, affiliated with, or controlled by the Policyholder. Eligible Affiliates are shown in the Declaration Page. Additions and terminations may only be made by an amendment to this Policy. Termination of an Affiliate is treated as termination of coverage for that company only.

AGENT means the Policyholder's representative, including but not limited to: the agent, producer or broker of record; or Claims Administrator.

ALTERNATE SPECIFIC DEDUCTIBLE means a separate Specific Deductible, if any, shown in Special Risk Limitations for certain Participants identified in the Policy which must be satisfied prior to any Specific Benefit becoming payable with respect to such Participant.

APPLICATION means the written request of an entity through its duly authorized representative(s) for insurance under this Policy on a form acceptable to us.

CATASTROPHIC CLAIM means any Known claim for a Covered Service(s) Incurred, or expected to be Incurred by a Participant that the Policyholder may reasonably assume will or has exceed(ed) 50% of the Specific Deductible.

CENSUS AND DEMOGRAPHIC INFORMATION means to provide the data requested by us in connection with the application for, or renewal of, this Policy on any Participant enrolled in a Covered Underlying Plan who is an active employee or member, laid off, on a leave of absence, retired, Medicare eligible, eligible for COBRA or COBRA participants, not actively at work, disabled, or confined to a hospital, and the number of Covered Units.

CLAIMS ADMINISTRATOR means the third party administrator(s) designated by the Policyholder and approved by us. The Claims Administrator(s) is/are shown on the Declaration Page.

CLAIM INFORMATION means to provide the data requested by us in connection with the application for, or renewal of, this Policy on any claim incurred, paid or pended on any Participant enrolled in a Covered Underlying Plan 30 days prior to the beginning of the Policy Term. Claim Information includes but is not limited to Catastrophic Claims, Large Claims and Shock Losses.

COVERED CLAIMS BASIS means the period as shown on the Specific Benefit Schedule of the Declarations Page during which an Eligible Claims Expense must be Incurred and the time period during which an Eligible Claims Expense must be Paid by the Policyholder for the Policy Term.

COVERED SERVICE(S) means any services, supplies or treatments for which the Participant has Incurred an Eligible Claims Expense and for which benefits are payable through the Covered Underlying Plan(s) during Covered Claims Basis for the Policy Term. This does not include Excluded Claims Expenses or any services, supplies or treatments excluded under Special Risk Limitations.

COVERED UNDERLYING PLAN(S) means the plans, which are identified in this Policy. This does not include any plan or portion of a plan, its subsidiaries or any other part of a group that has been excluded under Special Risk Limitations.

COVERED UNIT(S) means a group of one or more Participants composed of one or more of the following types of Covered Units:

Composite - an employee, associate or member and all of his or her dependents.

Eligible for coverage under a Covered Underlying Plan.

DEDUCTIBLE(S) means the Specific Deductible or Alternate Specific Deductible as shown in the Specific Benefit Schedule or under Special Risk Limitations.

DISCLOSURE OR DISCLOSED means to provide Claim Information and any other documentation or data requested by us including but not limited to Census and Demographic Information and the estimated number of Participants prior to the beginning of the initial Policy Term.

EFFECTIVE DATE means the date shown on the cover page of this Policy.

ELIGIBLE CLAIMS EXPENSE means an expense for a Covered Service which is Incurred by a Participant and for which benefits have been Paid by the Policyholder during the Covered Claims Basis of the Policy. This term does not include an expense:

1. Not specifically included under the terms of the Covered Underlying Plan; or

2. Excluded under the terms of the Covered Underlying Plan; or

3. Excluded under the terms of this Policy including Excluded Claims Expenses, if any, shown in Special Risk Limitations; or

4. Paid but subsequently recovered by the Policyholder from any third party, including but not limited to manufacturer discounts and amounts received as prescription drugs or pharmacy rebates.

EXCLUDED CLAIMS EXPENSES means expenses which are Incurred by a Participant for services, supplies or treatments for, or related to, the condition, or resulting complications of an injury or sickness described in the Exclusions and Limitations and the Special Risk Limitations.

FAMILY means an employee, associate, member or student of the Policyholder, and the eligible dependents of such person who are covered, or who become eligible for coverage, through a Covered Underlying Plan.

INCURRED means that the Participant(s) received a service, supply or treatment for an Eligible Claims Expense during the Covered Claims Basis of the Policy Term. The date upon which a service, supply or treatment is received by the participant is considered the date on which it was Incurred.

KNOWN means information affecting the administration or underwriting of this Policy, which a reasonable person can assume the Policyholder or the Policyholder's Claims Administrator had actual knowledge of prior to a request for Disclosure, Claim Information or prior to a Material Change.

LARGE CLAIM, SHOCK CLAIM OR SHOCK LOSS means any loss that is reasonably likely to result in a potentially Catastrophic Claim, or any other loss due to the nature of the injury, illness or diagnosis that the Policyholder or the Policyholder's Claims Administrator reasonably assumes will result in a significant medical expense in the current or next Policy Term.

MATERIAL CHANGE or CHANGE includes, but is not limited to, the following:

1. A change in:

    a. The Census and Demographic information or Claim Information submitted by the Policyholder upon which our assessment of risk is based; or
    b. The Covered Underlying Plans(s) benefit description, eligibility requirements, limitations or exclusions; or
    c. The Claims Administrator.

2. A change in the number of Covered Units shown on the Declaration Page of the Policy by more than 10%.

3. A bankruptcy proceeding involving the Policyholder or an Affiliate.

MAXIMUM SPECIFIC BENEFIT means the maximum dollar amount we will pay the Policyholder per Participant for the Specific Benefit. The Maximum Specific Benefit is shown in the Specific Benefit Schedule.

PAID means the date:

1. Eligible Claims Expenses have been processed and approved for payment by the Policyholder or the Policyholder's Claims Administrator in accordance with the Policyholder's or Claims Administrator's standard business practices; and

2. A check or draft for remuneration has been processed or is otherwise delivered to the payee electronically or in person; or a credit transaction has been agreed to by the Policyholder or the Policyholder's Claims Administrator and received by the payee electronically or in person; or the Policyholder has issued definitive payment instructions to a payment clearinghouse or similar entity.

A claim will not be considered Paid until both of these conditions are satisfied. A draft or check returned to the Policyholder or Claims Administrator for any reason, or any credit transaction not honored by the payee for any reason, or any payment returned by a clearinghouse to the Policyholder or Claims Administrator for any reason will not be considered Paid.

PARTICIPANT(S) means a person who is enrolled in a Covered Underlying Plan and meets all of the Covered Underlying Plan's eligibility requirements including requirements for coverage pursuant to COBRA, if applicable.

PHARMACY BENEFIT MANAGER(S) means the third party administrator(s) designated by the Policyholder and approved by us for the administration of prescription drug benefits. The Pharmacy Benefit Manager(s) is/are shown on the Declarations Page.

POLICY means this contract between the Policyholder and us with respect to Stop Loss Insurance.

POLICY ANNIVERSARY means each anniversary of the Effective Date of the Policy, unless changed by agreement between the Policyholder and us.

POLICY MONTH means successive intervals of time, while the Policy is in effect, determined on a monthly basis starting on the Effective Date of the Policy. Each new interval will begin on a day that corresponds to the Effective Date of the Policy. If there is no such day in any applicable month, then the last day of the month will be used.

POLICY TERM means the time period shown in the Declaration Page. For purposes of this definition:

1. An initial Policy Term is the period of time from the Effective Date of the Policy to the date of the first Policy Anniversary.

2. A current or renewal Policy Term is the period of time either from the Effective Date of the Policy, or the date of the last Policy Anniversary, to the date of the next Policy Anniversary.

Each Policy Term after the initial Policy Term will begin on the Policy Anniversary. The initial Policy Term will begin on the Effective Date of the Policy.

POLICYHOLDER means the entity shown on the cover page of this Policy.

PREMIUM DUE DATE means the Effective Date of this Policy and the first day of each following Policy Month.

PROVIDER(S) means a person, company or facility that provides medical services, supplies or treatments that are covered under the terms of the Covered Underlying Plan, and for which the Policyholder is required to pay a benefit in accordance with the terms of the Covered Underlying Plan.

SPECIAL RISK LIMITATION means any modification of the Policy within the terms and conditions of the Policy and state law.

SPECIFIC BENEFIT means the benefit paid when Eligible Claims Expenses Paid by the Policyholder for a Participant in the Covered Claims Basis for the Policy Term exceed the Specific Deductible.

SPECIFIC DEDUCTIBLE means the amount of Eligible Claims Expenses which must be Paid by the Policyholder for a Participant during the Covered Claims Basis for the Policy Term before a Specific Benefit is paid to the Policyholder. The Specific Deductible is shown in the Specific Benefit Schedule.

SPECIFIC PAYABLE PERCENTAGE means the percentage of the Specific Benefit that will be paid to the Policyholder in excess of the Specific Deductible. The Specific Payable Percentage is shown in the Specific Benefit Schedule.

STOP LOSS INSURANCE means the coverage provided under this Policy, which provides benefits to the Policyholder when Eligible Claims Expenses which are Paid by the Policyholder through the Covered Underlying Plan(s) exceed the levels defined in this Policy.

Part 3. BENEFITS

Benefits under this Policy will only be paid by us based on Eligible Claims Expenses through the Covered Underlying Plan(s) which are Incurred and Paid within the Covered Claims Basis for the Policy Term.

A. SPECIFIC BENEFIT

Subject to the terms and conditions of this Policy, we will pay the Policyholder a Specific Benefit as it becomes due following satisfaction of the Specific Deductible.

The Specific Benefit payable with respect to a Participant will equal the amount of Eligible Claims Expenses which are Incurred and Paid by the Policyholder for such Participant during the Covered Claims Basis for this Policy Term minus A plus B where:

A = The Specific Deductible for the Participant.

B = Any amounts Paid for Eligible Claims Expenses Incurred by a Participant later recovered through any recovery provision of this Policy or the Covered Underlying Plan.

Times the Specific Payable Percentage.

In no event will the Specific Benefit paid by us with respect to Eligible Claims Expenses Incurred by any one Participant exceed the Maximum Specific Benefit.

The Specific Benefit payable does not include any amount Paid by the Policyholder for the Policy Term for Excluded Claims Expenses.

Part 4. EXCLUSIONS AND LIMITATIONS

We will not pay the Policyholder a benefit under this Policy for:

1. COVERED UNDERLYING PLAN: Any amount Paid by the Policyholder for an expense:

    a. Incurred when the Covered Underlying Plan is not in effect; or

    b. Incurred by a person who is not a Participant as defined by the Covered Underlying Plan when the expense is Incurred; or

    c. That is not specifically covered under the terms of the Covered Underlying Plan, or that the Policyholder is not required to pay in accordance with the terms of the Covered Underlying Plan; or

    d. That is not Incurred and Paid within the Covered Claims Basis as shown in the Specific Benefit Schedule(s).

2. NONDISCLOSURE: Any amount which is Paid by the Policyholder for an expense which is Incurred by a Participant if such Participant's Known Census and Demographic Information and Claim Information were not accurately Disclosed to us by the Policyholder or the Policyholder's Claims Administrator:

    a. Prior to the initial underwriting of this Policy; or

    b. Upon request prior to:

        1. renewal; or

        2. the date a Participant becomes eligible for coverage through a Covered Underlying Plan; or

        3. the date the number of Covered Units changes by more than 10%.

3. OTHER COVERAGE: The amount of any expenses for benefits to any Participant with coverage under any other plan which, when combined with the benefits payable by such other plan, would cause the total paid by that plan and the Covered Underlying Plan(s) to exceed 100% of the Participant's Eligible Claims Expenses.

4. ADMINISTRATIVE COSTS: Any amount accumulated by the Policyholder for administrative costs, including but not limited to, such costs for:

   a. Administrative costs, including but not limited to costs for claims administration, claim payments, prescription drug administration fees, PPO access fees and any percentage of savings that is derived from utilization of any networks; or

   b. Capitation fees; or

   c. The expense of litigation; or

   d. Extra contractual damages, compensatory damages, or punitive damages; or

   e. Negotiation Fees unless satisfactory proof of loss is provided which demonstrates actual cost savings, in which case, fees actually paid to qualified vendors by the Policyholder may be reimbursed up to 25% of savings; or

   f. Case Management Fees unless satisfactory proof of loss is provided, in which case, fees actually paid to qualified case management vendors by the Policyholder may be reimbursed up to $150 per hour for hourly billed case management charges.

5. LOST PROVIDER DISCOUNTS: Provider discounts of any kind lost due to untimely payment of claims by the Policyholder, Claims Administrator or a third party vendor retained by either the Policyholder or Claims Administrator.

6. WAR: Any amount Paid by the Policyholder for Eligible Claims Expenses which arise out of or are caused or contributed to by war or an act of war.

   WAR means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.

7. WORK RELATED: Any amount Paid by the Policyholder through the Covered Underlying Plan(s) for any injury or illness which is eligible for coverage under a workers' compensation or occupational disease policy or agreement, whether or not such policy or agreement is in force and whether or not such benefits are received by the Participant.

Part 5. CLAIMS ADMINISTRATOR

The Policyholder must retain a Claims Administrator at all times. All Claims Administrators must be approved by us. The Claims Administrator performs as the Policyholder’s agent and we will not be held liable for any act or omission of the Claims Administrator.

We will only reimburse the Policyholder for Eligible Claims Expenses paid by an approved Claims Administrator.

The Policyholder must ensure that its Claims Administrator:

1. Supervises the administration and adjustment of all claims and verifies the accuracy and computation of all claims in accordance with the terms of the Covered Underlying Plan;
2. Maintains accurate records of all claim payments;
3. Maintains separate records of expenses not covered;

4. Provides us with the following data for the preceding Policy Month on or before the 30th day of each succeeding Policy Month:

   a. notice of claims Incurred by a Participant that reach 50% of the Specific Deductible; and
   b. number of Covered Units; and
   c. total amount of claims paid.

5. Secures and keeps renewed, at their expense, all licenses, permits, authorizations or certificates of authority in the states where the Claims Administrator conducts the business of benefit plan administration in accordance with statutory requirements.

We will not be responsible for any compensation due to the Claims Administrator for functions performed by the Claims Administrator for the Policyholder.

This Policy will not be deemed to make us a party to any agreement between the Policyholder and the Claims Administrator.

For the purpose of any notice required from us under the provisions of this Policy, notice to the Policyholder's Claims Administrator will be considered notice to the Policyholder and notice to the Policyholder will be considered notice to the Policyholder's Claims Administrator.

Part 6. CLAIM PROVISIONS

A. NOTICE REQUIREMENT

The Policyholder or the Policyholder’s Claim’s Administrator must notify us when:

1. A Participant has Incurred Eligible Claims Expenses through the Covered Underlying Plan for a Catastrophic Claim, Large Claim or Shock Loss; or

2. A Participant has Incurred Eligible Claims Expenses through the Covered Underlying Plan that exceed 50% of the Specific Deductible.

Such notification regarding Eligible Claims Expenses Incurred by a Participant must include:

1. The identity of or unique identifier associated with the Participant.

2. A description of the illness, diagnosis or accident and the prognosis.

3. A listing of the Eligible Claims Expenses Incurred by or Known to the Policyholder to date through the Covered Underlying Plan.

Failure to give such notice will not invalidate or reduce any claim if it is shown not to have been reasonably possible to give such notice in time and that notice was given as soon as was reasonably possible.

B. PROOF OF LOSS

The Policyholder or the Policyholder’s Claims Administrator must provide satisfactory proof of loss to support a claim within 90 days after the end of the Covered Claims Basis for the Policy Term. Policyholder’s failure to provide a proof of loss within this time will not invalidate or reduce any reimbursement if it were not reasonably possible to submit said request within such time. However, the request must be submitted as soon as possible but in no event later than 12 months after the last date of the Covered Claims Basis of the Policy Term then in effect.

Upon presentation of satisfactory proof of loss the Policyholder represents that:

1. All applicable Deductibles have been satisfied; and

2. Monies necessary to pay for services and supplies have been paid to the Participant or respective Providers of medical services or supplies to which the claim for reimbursement under the Policy relates.

Satisfactory Proof of Loss may include but not be limited to:

1. Completed claim form(s);
2. Participant's name and Date of Birth;
3. Proof of the Participant's eligibility and enrollment records;
4. Paid claim report which includes for each claim:

    - Claimant Identification
    - Incurred date
    - Provider name and tax identification number (TIN)
    - Billed amount, allowed amount, and paid amount
    - Paid date
    - Relevant International Classification of Diseases (ICD-10) codes, Current Procedural Technology (CPT) codes, and National Drug Code (NDC) codes
    - Documentation demonstrating claims were paid in accordance with the Covered Underlying Plan's terms and conditions;

5. Copies of all relevant provider bills, reports and electronic data transactions;
6. Copies of relevant pre-certification forms;
7. Amounts of any discounts or rebates received;
8. Continuation of Coverage documentation;
9. Coordination of Benefits documentation;
10. Summary Plan Document;
11. Clinical Notes for billed charges exceeding $200,000;
12. If applicable copies of the police report and any signed subrogation agreement;
13. Any other documentation that we may need to adjudicate your request for reimbursement.

C. PAYMENT OF CLAIM

Subject to satisfactory proof of loss, any benefits payable under the Policy will be paid within 45 days immediately following our receipt of such proof of loss.

D. EXTENDED LIABILITY

If a Participant has a claim denied by the Covered Underlying Plan and that denial is subsequently reversed by an Independent Review Organization (IRO) the date the claim was originally denied by the Covered Underlying Plan will be considered the "Paid" date under the above referenced Policy.

Independent Review Organization (IRO) means the organization for external review as required under the external review process of the Patient Protection and Affordable Care Act.

Part 7. MATERIAL CHANGES

We reserve the right to approve any Material Change or Change, including those required by applicable law. The Policyholder or the Policyholder's Claims Administrator must notify us of any Change in writing prior to the effective date of such Change.

Upon receipt of a Material Change we reserve the right to:

1. Accept the Change without revising the Premium Rates and/or other terms and conditions of this Policy; or

2. Accept the Change and reasonably revise the Premium Rates and/or other terms and conditions of this Policy; or

3. Not accept the Change and pay benefits under this Policy as if the Change had not occurred.

4. Not accept the Change and terminate this Policy.

If we accept the Change we will consider the Change approved on the date of the Change. Payment of any benefits under this Policy based on a Change is subject to the Policyholder's written acceptance of any necessary adjustment to the premium.

Part 8. TERMINATION AND RENEWAL

A. TERMINATION

This Policy and all coverage under this Policy will terminate 11:59 PM Eastern Time on the earliest of the following dates:

1. The end of the last period for which premiums were paid.

2. The last day before the Premium Due Date following receipt by us of written notice from the Policyholder that this Policy is to be terminated.

3. The end of any Policy Term, following 30 days prior written notice to the Policyholder of termination.

4. The last day before the Premium Due Date following 30 days prior written notice to the Policyholder that we are planning to terminate this Policy because:

   a. there are fewer than 50 Covered Units; or
   b. we have refused to accept a Material Change; or
   c. the Policyholder has refused to accept any necessary adjustment to the premium due to a Material Change.

5. The date the Covered Underlying Plan(s) and all coverage under such plan(s) end.

6. The date of cancellation of the administrative agreement between the Policyholder and the Policyholder's Claims Administrator, unless the Policyholder has selected another administrator prior to such cancellation and we have consented to the Policyholder's selection in writing.

7. On any date mutually agreed to by the Policyholder and us.

B. EARLY TERMINATION

If this Policy terminates prior to the end of the Policy Term the Covered Claims Basis of this Policy will be limited to Eligible Claims Expenses Incurred and Paid by 11:59 PM Eastern Time up to the date this Policy terminates.

C. RENEWAL

Unless terminated during or prior to the end of the Policy Term, this Policy may be renewed. At that time we reserve the right to revise the terms and conditions that apply to the Policy (including but not limited to the rates, deductibles, and factors) by providing written notice to the Policyholder.

Renewal is subject to:

1. Receipt of any requested Census and Demographic Information and Claim Information prior to the beginning of the subsequent Policy Term; and

2. The Policyholder's written acceptance of the terms and conditions that apply to the renewal prior to the beginning of the subsequent Policy Term.

At renewal We will not apply any new Special Risk Limitation including but not limited to an Alternate Specific Deductible or Excluded Claim Expense unless requested by the Policyholder or his or her authorized representative.

Part 9. PREMIUMS

A. MONTHLY PREMIUM

The premium due each month is calculated based upon:

1. The type(s) of Covered Units shown under Number of Covered Units in the Specific Benefit Schedule; and

2. The number of Covered Units reported in the Policy Month.

Any adjustments in premium due to enrollment changes should specify the enrollment adjustment for each Covered Unit by coverage type and the Policy Month for which the adjustment applies, and include the corresponding premium adjustment.

B. CHANGES IN PREMIUM RATES

We reserve the right to change any rate or percentage used in determining the monthly premium. The change may occur on one of the following dates:

1. On any Premium Due Date, if the number of Covered Units shown on the Declaration Page of the Policy changes by more than 10%.

2. On any Premium Due Date if we determine that claim payments are not being made in accordance with the terms and conditions of the Covered Underlying Plan(s).

3. On the first Premium Due Date coincident with or following the date of a Material Change approved by us.

4. On the first Premium Due Date coincident with or following the date the Policyholder replaces the current Claims Administrator, provided we have consented to the change in writing.

5. On any Policy Anniversary.

6. At the end of any Policy Term.

We will give the Policyholder 60 days prior written notice of any change in any rate or percentage used in determining the monthly premium.

C. PAYMENT OF PREMIUMS

All premiums are due on the Premium Due Date. Each premium is payable by the Policyholder on or before the Premium Due Date to us at our Home Office. Except for the last month of the Policy Term the payment of each premium as it becomes due will maintain this Policy in force through the date immediately preceding the next Premium Due Date.

D. GRACE PERIOD

A Grace Period of 31 days will be allowed for the payment of each premium after the initial premium payment. Should a premium which is otherwise due, after the first month's Premium Due Date, not be paid during the Grace Period, this Policy will automatically terminate on the last day of the Policy Month for which premiums were last paid at 11:59 PM Eastern Time, without further notice to the Policyholder. Our liability will be limited to Eligible Claims Expenses that are Incurred by the Policyholder's Participants prior to 11:59 PM Eastern Time on last day of the Policy Month for which premiums were last paid.

E. PREMIUM ADJUSTMENTS

Any retrospective request by the Policyholder for a premium adjustment due to a misstatement of Covered Units must be made within 90 days following the end of the Policy Term. Such requests must be in writing and accompanied by evidence that an adjustment should be made.

Part 10. GENERAL PROVISIONS

A. HOLD HARMLESS

Both we and the Policyholder agree to hold each other harmless from any legal expenses sustained or judgments awarded arising out of any dispute involving a current or former Participant in the Policyholder's Covered Underlying Plan(s), to the extent such legal expenses or Judgments were not sustained as a result of either party's negligence or wrongful acts.

This provision shall survive the termination of this Policy.

B. TAXES

The Policyholder agrees to hold us harmless from any state taxes owed with respect to funds paid to or by the Policyholder through the Covered Underlying Plan(s). If any state tax is assessed against us with respect to such funds, the Policyholder must reimburse us for the amount of the state tax liability including any interest, penalty and costs paid by us as a result of the assessment. Taxes owed with respect to premiums paid for this Policy will be our responsibility.

C. ASSESSMENTS

State and federal laws may assess us based on the state of residence of Participants covered by this Policy. We reserve the right to increase premium rates to cover expected cost of any such assessment based on the number of Covered Units reported and the assessment rate in effect at the beginning of any Policy Term.

D. STATE HEALTH CARE SURCHARGES OR FEES

If you or your Claims Administrator pays a state mandated health care surcharge or fee in connection with the payment of Eligible Claim Expenses, such charge will be considered an Eligible Claim Expense.

Penalties or fines, including but not limited to late payment charges associated with such surcharge or any administrative expenses owed in connection with such payment will not be considered an Eligible Claim Expense.

E. NOTICE OF OBJECTION

Any objection, notice of legal action, or complaint received on a claim processed by the Policyholder or the Policyholder's Claims Administrator and on which it reasonably appears a benefit has been or will be payable to the Policyholder under this Policy, must be brought to the immediate attention of our claims department.

F. POLICY NON-PARTICIPATING

This Policy is non-participating and the Policyholder is not entitled to share in our surplus earnings.

G. OFFSET

We have the right to offset any benefits payable to the Policyholder under this Policy against premiums or other payments that are due and unpaid by the Policyholder, but this right will not prevent the termination of this Policy for non-payment of premium or failure to abide by any other term of this Policy.

H. RECOVERY

The Policyholder must prosecute any and all valid claims that the Policyholder may have against third parties arising out of any occurrence resulting in a payment for Eligible Claims Expenses by the Policyholder and must account to us for any amounts recovered.

However, if the Policyholder does not prosecute any and all valid claims that the Policyholder may have against third parties arising out of any occurrence resulting in a payment for Eligible Claims Expenses by the Policyholder within a reasonable period of time, we may, at our discretion, either subrogate the recovery of such claims on behalf of the Policyholder or require the Policyholder to assign us the right to prosecute such claims on behalf of the Policyholder.

At that time we may, at our option, bring legal action to recover from the third party the amount of any benefits we paid to the Policyholder in connection with the payment of Eligible Claims Expenses caused by the third party's negligence or wrong-doing. The Policyholder will be required to provide us with any legal instruments, documents, or a paper we may need to exercise our right to recover and the Policyholder is prohibited from doing anything to prejudice our right to recover payments from the third party.

This provision shall survive the termination of this Policy.

I. REIMBURSEMENT

The Policyholder must repay us for any Eligible Claims Expenses recovered from any third party for which a benefit was paid under this Policy. This includes any prescription drug or pharmacy rebates that are received by the Policyholder for which a prescription drug or pharmacy benefit was paid by us for Eligible Claims Expenses under this Policy. This provision will survive the termination of this Policy.

J. WAIVER

Our failure to insist upon the Policyholder's or the Policyholder's Claim Administrator's strict compliance with any requirement or condition of this Policy at any time or under any circumstance will not constitute a waiver of any such requirement or condition by us at any time under the same or different circumstances.

K. ARBITRATION

In the event of a dispute between the parties to this Policy as to whether coverage is provided under this Policy for a claim made by or against the Policyholder, both parties may, by mutual consent, agree in writing to arbitration of the disagreement.

If both parties agree to arbitrate, each party will select an arbitrator. The two arbitrators will select a third arbitrator. If they cannot agree within 30 days upon a third arbitrator, both parties must request that selection of a third arbitrator be made by a judge of a court having jurisdiction.

Unless both parties agree otherwise, arbitration will take place in Allegheny County, Pittsburgh, PA.

Local rules of law as to procedure and evidence will apply.

A decision agreed to by any two will be binding. Each party will:

1. Pay the expenses it incurs; and

2. Bear the expenses of the third arbitrator equally.

L. RECOVERY OF OVERPAYMENT

If benefits are overpaid, we have the right to recover the amount overpaid by either of the following methods:

1. A request for lump sum payment of the overpaid amount.

2. A reduction of any amounts payable under this Policy.

This provision shall survive the termination of this Policy.

Part 11. RECORDS AND REPORTS

A. REPORTING

The Policyholder or the Policyholder's Claims Administrator must:

1. Keep appropriate records regarding administration of the Covered Underlying Plan(s); and

2. Allow us to review and copy, during normal business hours, all records affecting our Liability under this Policy; and

3. Submit and/or allow access to all proofs, reports, and supporting documents requested by us relating to this Policy, including, but not limited to, a monthly summary of all Eligible Claims Expenses which were processed by the Policyholder or the Policyholder's Claims Administrator on a timely basis.

B. CLERICAL ERROR

Clerical error, whether by us, or by the Policyholder or the Policyholder's Claims Administrator, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

C. AUDITS

We reserve the right to inspect and audit all of the Policyholder's and the Policyholder's Claims Administrator's records and procedures that pertain to this Policy. We also reserve the right to require proof that payment of Eligible Claims Expenses has been made to the Participant or the Provider of the Covered Services that are the basis for any claim by the Policyholder under this Policy.

This provision shall survive the termination of this Policy.

D. UNDERWRITING INFORMATION

We rely on the information (including but not limited to Census and Demographic Information and Claim Information) provided by the Policyholder or the Policyholder's Claims Administrator:

1. To issue this Policy; and

2. To accept a person as a Participant; and

3. To renew this Policy.

Should additional information become Known that affects the terms and conditions of this Policy (including but not limited to the rates, deductibles, corridor and factors) we reserve the right to revise the terms and conditions of this Policy on any Premium Due Date by providing written notice to the Policyholder.

Part 12. LIABILITY

We will have neither the right nor the obligation under this Policy to directly pay any Participant or Provider of Covered Services for any benefit that the Policyholder has agreed to provide through the terms of the Covered Underlying Plan(s). Our sole liability under this Policy is to the Policyholder.

Part 13. INDEMNIFICATION

To the extent either we or the Policyholder suffers any liability, loss or expense due to a breach of this Policy by either party or due to the other party's negligence or wrongful acts, each party agrees to indemnify the other up to the amount of such liability, loss or expense, and all costs associated with such liability, loss or expense.

Part 14. ENTIRE CONTRACT, CHANGES

The entire contract consists of:

1. The pages of this Policy including any amendments, endorsements or riders; and

2. The Application; and

3. Submitted Claim Information; and

4. Disclosure statements and/or Disclosure forms; and

5. Attached documents necessary for the administration of this Policy.

This Policy or the Policyholder's coverage under this Policy may be amended at any time by mutual consent between the parties. No change in this Policy will be valid unless it is approved in writing by one of our executive officers and delivered to the Policyholder for attachment to this Policy. This approval must be shown on or attached to this Policy. No Agent or Claims Administrator has authority to change this Policy or to waive any of its provisions.

Part 15. INCONTESTABLE CLAUSE

Any statement made by the Policyholder is a representation and not a warranty. No statement made by the Policyholder affecting this Policy will be used to deny a claim or to deny the validity of this Policy unless contained in a written instrument signed by the Policyholder and a copy of the written instrument has been given to the Policyholder.

Part 16. LEGAL ACTIONS

No action at law or in equity may be brought to recover under this Policy until 60 days after satisfactory proof of loss has been furnished to us. No such action may be brought more than three years after the time within which proof of loss is required to be furnished.

Part 17. INSOLVENCY

The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder or the Policyholder's Claims Administrator will not impose upon us any liability other than the liability defined in this Policy.

Part 18. ASSIGNMENT

The Policyholder's rights and benefits under this Policy cannot be assigned to any person or entity, including but not limited to any Participant, medical provider, or creditor.

HM LIFE INSURANCE COMPANY

FIFTH AVENUE PLACE, 120 FIFTH AVENUE, PITTSBURGH, PA 15222-3099

1-800-328-5433

RENEWAL RIDER

To be attached to and made part of Policy 407517-B issued to City of Mesquite as Policyholder.

It is hereby agreed effective January 01, 2022 that Policy 407517-B replaces Policy 407517-A for the Policy term beginning January 01, 2022 and ending December 31, 2022 in its entirety.

All terms and conditions of Policy 407517-B will apply including but not limited to recovery of any overpayment(s) due under the prior policy and reapplication of any applicable Deductibles in the next Policy Term. Please refer to the attached Declarations page(s) for your current benefit and premium information applicable under Policy 407517-B.

HM Life Insurance Company

By

President