PartnerRe

Excess Loss Insurance Policy

PartnerRe America Insurance Company
Wilmington, DE
NAIC# 11835

Mailing Address:
450 Sansome Street, 4th Floor
San Francisco, CA 94111
800 385 6802

This Policy is issued to:

Policyholder Weslaco ISD

Policy Number P0312973101

Policy Period From: September 1, 2016 To: September 1, 2017

(All insurance begins and ends at 12:01 A.M. standard time at the Policyholder's Principal Address as shown in the Schedule)

The Company agrees to reimburse the Policyholder for certain benefits provided herein. Such reimbursement will be subject to all the terms and conditions of this Policy.

This Policy is issued in consideration of:
- the Application made by the Policyholder;
- Disclosure and] receipt of Claim Information;
- the payment of the initial premium as of the Effective Date of this Policy;
- the payment of all subsequent premiums when due; and
- the continual compliance by the Policyholder with all terms and conditions of this Policy.

This Policy is governed by the laws of the state of Texas.

The provisions on the following pages are a part of this Policy. Please review this Policy carefully.

Company obligations under this Policy are limited to the terms, conditions and limitations of this Policy. We are not a party to, responsible for or a guarantor of the benefits provided under the Benefit Plan. We are not a Plan Administrator or a Fiduciary with respect to the Benefit Plan as those terms are used in the Employee Retirement Income Security Act of 1974, as amended.

[IN WITNESS WHEREOF, the Company has caused this Policy to be executed and attested and, where required by law, this Policy shall not be valid unless countersigned by its duly Authorized Representative(s).

Daniel R. Bolgar
President
PartnerRe America Insurance Company

Thomas L. Forsyth
Corporate Secretary
PartnerRe America Insurance Company

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SECTION I - SCHEDULE OF INSURANCE

In the event of a conflict between the terms, conditions and limitations of this Schedule of Insurance and the Excess Loss Insurance Policy, this Schedule of Insurance will control.

1. POLICYHOLDER: Weslaco ISD
   Principal Address: 319 West Fourth Street
   Weslaco, TX 78599

2. POLICY NUMBER: P0312973101

3. POLICY PERIOD: Effective Date: September 1, 2016
   Termination Date: September 1, 2017

4. CLAIM ADMINISTRATOR: Frates Benefit Administrators
   Address: 13439 Broadway Extension, Suite 110
   Oklahoma City, OK 73114

5. EXCESS LOSS INSURANCE:

   a. SPECIFIC: ☒ Yes ☐ No

      i. Benefits To Be Covered:
      Medical
      Prescription Drug Plan

      ii. Coverage Period:
      Incurred in 12 months and Paid in 15 months

      Specific Deductible: $125,000 per Individual

      iii. Specific Benefit Percentage: 100 %

      iv.

Specific Premium:	Covered Persons:	Premium Rate
Single:	2,286	$55.66

      Premium Payable: Monthly

      Minimum Premium: $1,297,800

      v. Maximum Specific Benefit:
      Specific Lifetime Maximum: Unlimited
      Specific Annual Maximum: Unlimited

   b. AGGREGATE: ☒ Yes ☐ No

      i. Benefits To Be Covered:
      Medical
      Prescription Drug Plan

ii. Coverage Period:
Incurred in 12 months and Paid in 15 months

iii.

Aggregate Coverage	Covered Persons	Monthly Expected Claims	Aggregate Attachment Point %	Monthly Aggregate Attachment Point
Single:	2,286	$559.15	125%	$698.94

Minimum Annual Aggregate Deductible: $19,173,322

Aggregate Limit of Liability: $1,000,000 per Coverage Period

iv. Aggregate Benefit Percentage: 100%

v.

Aggregate Premium:	Covered Persons:	Premium Rate
Single:	2,286	$0.49

Premium Payable: Monthly

6. GENERAL CONDITIONS:

a. All retirees are excluded under Specific and Aggregate Excess Loss Insurance Coverage

b. Minimum Enrollment Required for Renewal of Coverage: 100 enrolled Covered Persons covered for Medical.

c. Actively at Work requirement waived: Yes ☒ No☐

d. Other: The Plan Benefits for 31502171F(01) is Medical Only (rx excluded from Stop Loss)

7. OPTIONAL ENDORSEMENTS:

a. The following endorsement(s) are included in the Specific Excess Loss Insurance Coverage:
i. Aggregated Specific Deductible

SECTION II - DEFINITIONS

Administrative Manual means the document which details the administrative procedures and instructions to be followed by You in the payment of premium, submission of claims and administration of this Policy.

Aggregate Attachment Point Percentage means the Aggregate Attachment Point Percentage as shown on the Schedule of Insurance.

Benefit Month means any calendar month during which this Policy is in force.

Benefit Percentage means the percentage of Eligible Expense the Company will consider eligible reimbursement after the application of the Specific Deductible.

Benefit Plan means a self-funded plan of benefits which the Policyholder provides for eligible Covered Persons and their eligible Covered Dependents. The benefits are described in a written plan document. A copy of the written plan document in effect on the Effective Date of this Policy is attached to the Excess Loss Insurance Application. Amendments to the Benefit Plan will be covered by this Policy when they become effective under such plan only to the extent provided in the Material Change Provisions section of this Policy.

Claim Administrator means a firm or person which has entered into a written agreement with You to pay claims for the Benefit Plan and who has been approved by Us. The Claim Administrator acts on Your behalf and as Your agent and not as Our agent. The duties of the Claim Administrator under this Policy are described in the Claim Administrator Responsibilities section of this Policy.

Claim Information means Complete Details following a Diligent Review of data requested by the Company in connection with the application for, or renewal of, this Policy on any claim Incurred, Paid or pended prior to Disclosure, the initial underwriting, the Effective Date of this Policy or the renewal of this Policy following the end of any Policy Period.

Claim Disclosure Statement means the document submitted and signed by the Applicant, Policyholder or Claim Administrator which identifies and provides the Claim Information following a Diligent Review, upon which We will rely, to issue or renew the Policy, or to accept additional risk under the Policy at any time during the current Policy Period.

Company, We, Us and Our means PartnerRe America Insurance Company.

Complete Details means detailed information including but not limited to the Covered Person's or Covered Dependent's name, member number or other unique identifier, date of birth, admission date, estimated discharge date, diagnosis, prognosis (unless prognosis cannot be obtained due to reasons beyond the control of the Policyholder or its designated representative) and expenses incurred to date, on any Covered Person or Covered Dependent covered, or eligible for coverage, under a covered Benefit Plan.

Coverage Period means the time period as shown on the Schedule of Insurance.

Covered Dependent(s) means, subject to the terms, conditions and limitations of this Policy, a Covered Person's dependent who is covered by the terms of the Benefit Plan. If a person becomes a dependent of a Covered Person and such dependent is covered under the terms of the Benefit Plan, coverage will be provided under this Policy for expenses Incurred by You on behalf of such dependent.

Covered Person means a person enrolled in the Benefit Plan who is entitled to receive benefits under that Plan while this Policy is in force. A Covered Person includes:

1. Legally employed covered employees of Yours;
2. Participating COBRA beneficiaries; and

Cost Containment Vendor means a third party contracted to reduce or control the cost of services or supplies provided to Covered Persons and Covered Dependents under the Benefit Plan.

Deductible(s) means the Specific Deductible(s), [Adjusted Specific Deductible(s),] or Aggregate Deductible as shown in the SECTION I - SCHEDULE OF INSURANCE and as detailed in SECTION III, AGGREGATE EXCESS LOSS INSURANCE or Aggregating Specific Deductible, shown in the Aggregating Specific Deductible Endorsement.

Diligent Review means a complete review by the Policyholder, its designated representative or the Claim Administrator prior to Disclosure, the initial underwriting, the Effective Date or the renewal of this Policy following the end of any Policy Period for Known potential Serious Claims. A claimant is Known if prior to or at the time of Disclosure, or Claim Information is requested the Policyholder had information about the claim, or could have reasonably been assumed to have had such information, had they conducted a Diligent Review.

Disclosure Or Disclosed means the provision, following a Diligent Review, to the Company of Complete Details of all documentation requested, including but not limited to, the information requested on the Claim Disclosure Statement and in connection with the quote/proposal for the initial underwriting or for renewal underwriting of subsequent Policy Periods, membership information and Claim Information within the time period(s) specified by the Company in writing prior to the initial underwriting of this Policy, the Effective Date of this Policy or the renewal of this Policy following the end of any Policy Period.

Domestic Claims are claims for Eligible Expenses provided by the Policyholder or at facilities named in the Schedule of Insurance to a Covered Person and for which benefits are payable through the Benefit Plan.

Effective Date means the date shown on the cover page of this Policy and item 3. of the Schedule of Insurance.

Eligible Aggregate Expenses means Eligible Aggregate Expenses as defined in the Aggregate Excess Loss Insurance section of the Policy if this coverage is elected by the Policyholder.

Eligible Expenses means either Eligible Aggregate Expenses or Eligible Specific Expenses.

Eligible Specific Expenses means Eligible Specific Expenses as defined in the Specific Excess Loss Insurance section of the Policy if this coverage is elected by the Policyholder.

Endorsement(s) means the document(s) listed in item 7 of the Schedule of Insurance and attached to this Policy that modifies the Policy by changing the coverage afforded under the Policy.

Excess Loss Insurance means the coverage provided under this Policy, which provides benefits to You when Eligible Expenses which are Paid by You through your covered Benefit Plan(s) exceed the Deductibles defined in this Policy.

Expected Claims means the amount of claims that, in the absence of an excess loss policy or other insurance or evidence of coverage, are projected by Us to be Incurred under a Benefit Plan covering health care expenses.

Experimental Or Investigational, for the purpose of determining Eligible Expenses under this Policy, means a treatment, device, or drug that:

1. is prescribed by a non-licensed Provider; or
2. is governed by the United States Food and Drug Administration ("FDA") and the FDA has not approved the treatment, device or drug for the particular condition at the time the treatment, device or drug is provided; or
3. except for "Approved Clinical Trials" as the term is defined in Title XXVII of the Public Health Service Act, Section 2709, is provided as part of an ongoing Phase I or II or III clinical trial as defined by the National Institutes of Health, National Cancer Institute or the FDA. In the event that an FDA approved drug or device is used for a particular condition during an ongoing Phase I or II or III clinical trial, and one or more other drugs or devices not FDA approved for such trial are also used, then all FDA approved and FDA non-approved drugs or devices shall be considered experimental or investigational; or
4. is documented in a major published U.S. peer-reviewed medical or scientific journal stating that further research, studies, or clinical trials are necessary to determine the safety, toxicity or efficacy of the treatment, device or drug; or
5. is any treatment, device, drug or hospital confinement that arises from, relates to, or is provided in connection with the Experimental or Investigational treatment or drug whether or not the treatment, drug or hospital confinement, on its own, is considered standard of care or Medically Necessary.

The Company will determine what is considered Experimental or Investigational for the purpose of determining Eligible Expenses under this Policy by reviewing the Claim Administrator's evaluation of the treatment, device or drug as well as studies, opinions and references to or by the American Medical Association, FDA, Department of Health and Human Services, National Institutes of Health, Council of Medical Specialty Societies, American Hospital Formulary Services Drug Information, American Academy of Pediatrics and any other association, federal program or agency that has the authority to approve medical testing or treatment.

Incurred means the date on which services relating to an Eligible Expense were provided to a Covered Person or a Covered Dependent under the Benefit Plan.

Known means information affecting the administration or underwriting of this Policy, which can be reasonably assumed that the Policyholder, its designated representative or Claim Administrator had knowledge of prior to or at the time of underwriting or a request for Disclosure or Claim Information.

Independent Review Organization means the organization for external review as required under the Patient Protection and Affordable Care Act and as utilized by the Benefit Plan.

Managed Care Network means a Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), Point of Service Plan (POS), self-funded Health Maintenance Organization (HMO), or any Managed Care Network offered by You.

Medically Necessary and Medical Necessity means a treatment, service, supply or medicine that:

1. is appropriate and essential for the diagnosis or treatment of the Covered Person's or Covered Dependent's symptoms;

2. is within the scope, duration or intensity of that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment;
3. is in accordance with generally accepted current professional medical practice, based on consultation with an appropriate service Provider; and
4. involves only the use of drugs or substances that are not Experimental or Investigational.

A treatment, service, supply or medicine will not be considered Medically Necessary if:

1. it is part of a treatment plan that is considered to be Experimental or Investigational or for research purposes; or
2. it is provided primarily as a convenience to the patient or the patient's family or the Provider of care.

The fact that a physician may prescribe, order, recommend or approve a treatment, service, supply or medicine does not, of itself, make it Medically Necessary.

Monthly Aggregate Attachment Point means the Monthly Expected Claims multiplied by the Aggregate Attachment Point Percentage, as shown on the Schedule of Insurance.

Monthly Expected Claims means the amount of Expected Claims per month per Covered Person. The initial Monthly Expected Claims are as shown on the Schedule of Insurance. We will re-determine the Monthly Expected Claims on each anniversary of the Effective Date of Your coverage under this Policy and on the effective date of each Material Change to the Benefit Plan.

Paid means the latest of the following dates:

1. The covered expense is approved by You according to the terms of the Benefit Plan; and
2. The draft or check is mailed, or the date the wire or other legal electronic transfer of funds has been issued by the Policyholder to the Covered Person or his or her assignee; and
3. Sufficient funds are on deposit on the date the check, draft or electronic transfer is issued to permit the check, draft or electronic transfer to be honored.

Policy means this Excess Loss Insurance Policy.

Policyholder, You and Your mean You, the Policyholder, shown on the face page of this Policy, who is described in the Excess Loss Insurance Application and who is approved for coverage by Us under this Policy.

Policy Period means the time period as shown on the Schedule of Insurance that is used in determining a Policyholder's eligibility for benefits under this Policy. The initial Policy Period is shown in the Excess Loss Insurance Application. Subsequent Policy Periods are shown on a separate, subsequent Schedule of Insurance(s).

Prescription Drug Plan means either a benefit provision of the Benefit Plan or a separate benefit plan maintained by You, under which prescription drug expenses are Paid independently of other medical expenses.

Proof of Loss means Proof of Loss as defined in the Premium and Claims Provisions section of this Policy**.**

Provider means any hospital, physician or other person or facility that is licensed or otherwise authorized to provide health care services.

Reasonable and Customary means the usual charge made by a Provider who renders or furnishes covered services, treatments or supplies; provided the charge is not in excess of the general level of charges made by other Providers who render or furnish the same or similar services, treatments or supplies to persons: 1) in the same geographical area; and 2) whose Injury or Illness is comparable in nature and severity.

If the Policyholder, Benefit Plan or Claim Administrator has a contracted fee arrangement with certain Providers, "Reasonable and Customary" shall mean the lesser of the applicable fee as defined in that fee arrangement contract or the usual charge made by the majority of like Providers for the same or like service in the same geographical area in which the service or treatment is performed.

Schedule of Insurance and **Schedule** mean SECTION I - SCHEDULE OF INSURANCE of this Policy.

Serious Claim(s) means any claim for any Eligible Expense on any Covered Person or Covered Dependent Incurred or Paid or pended or expected to be Incurred by a Covered Person or Covered Dependent that may reasonably be assumed will exceed 50% of the Specific Deductible in this or in the next Policy Period.

Specific Annual Maximum means the maximum amount of Eligible Specific Expenses We will apply towards the Specific Excess Loss benefit for a Covered Person or Covered Dependent during the Coverage Period. The Specific Annual Maximum is shown on the Schedule of Insurance.

Specific Lifetime Maximum means the maximum amount of Eligible Specific Expenses We will apply towards the Specific Excess Loss benefit for a Covered Person or Covered Dependent during the Covered Person's or Covered Dependent's lifetime. The Specific Lifetime Maximum is shown on the Schedule of Insurance.

Workers' Compensation means benefit payments to any eligible Covered Person or Covered Dependent as required by state law for accidents or occupational disease arising out of, or in connection with, the Covered Person's or Covered Dependent's employment.

SECTION III – EXCESS LOSS INSURANCE PROVISION

SPECIFIC EXCESS LOSS INSURANCE:

ELIGIBLE SPECIFIC EXPENSES

Eligible Specific Expenses are those claims Incurred and Paid within the Coverage Period shown on the Schedule of Insurance. All such expenses must be eligible expenses under the terms of the Benefit Plan, Medically Necessary, and covered under the terms of this Policy. The Coverage Period and rates for Specific Excess Loss Insurance are shown on the Schedule of Insurance. A separate Schedule of Insurance applies to each Coverage Period. Eligible Specific Expenses are the benefits which We have determined to be properly paid by You. Such benefits must be Paid during the Coverage Period to or on behalf of a Covered Person or Covered Dependent according to the terms of the Benefit Plan. However, such expenses are subject to both the Exclusions section of this Policy and the Schedule of Insurance. Expenses Incurred under a Prescription Drug Plan will be included as Eligible Specific Expenses only if Prescription Drug Plan is shown as included on the Schedule of Insurance. All claims are subject to Our Claim Audit per the Miscellaneous Provisions of this Policy.

The Company is not obligated to reimburse expenses which [are not considered Medically Necessary; or are Experimental or Investigative procedures which are not recognized by the Food and Drug Administration of the United States Government or other authoritative as generally accepted standards of medical practice.

WHEN BENEFITS WILL BE PAID
Specific Excess Loss benefits will be paid when a Covered Person or Covered Dependent has exceeded the Specific Deductible or Adjusted Specific Deductible, if applicable, during the Coverage Period shown on the Schedule of Insurance, subject to all of the terms, conditions and limitations of this Policy. Upon Our acceptance and approval of Proof of Loss, We will pay benefits to You for Eligible Specific Expenses that exceed the Specific Deductible or Adjusted Specific Deductible shown on the Schedule of Insurance for claims Paid that are:

A. Incurred while the Benefit Plan is in effect;
B. Paid according to the terms of the Benefit Plan; and
C. Incurred and Paid during the Coverage Period shown on the Schedule of Insurance.

AMOUNT OF BENEFIT PAYABLE
The Specific Excess Loss benefit payable is subject to the Maximum Specific Benefit limitations shown on the Schedule of Insurance and shall be equal to the product of:

1. The Specific Benefit Percentage, multiplied by
2. The amount of eligible benefits Paid to or on behalf of a Covered Person or a Covered Dependent under the Benefit Plan during the Coverage Period which exceeds the Specific Deductible or Adjusted Specific Deductible, if applicable.

The Specific Benefit Percentage, Specific Deductible and Coverage Period are shown on the Schedule of Insurance.

TO WHOM BENEFITS WILL BE PAID
Specific Excess Loss benefits will be paid to You. We will not make payment directly to any Covered Person, Covered Dependent, Provider or anyone else. You shall not represent Us as the insurer of benefits provided by the Benefit Plan**.**

AGGREGATE EXCESS LOSS INSURANCE:

ELIGIBLE AGGREGATE EXPENSES
Eligible Aggregate Expenses are claims Incurred and Paid within the Coverage Period as shown on the Schedule of Insurance. All such expenses must be eligible expenses under the terms of the Benefit Plan, Medically Necessary, and covered under the terms of this Policy. The Coverage Period and Monthly Expected Claims for Aggregate Excess Loss insurance are shown in the Schedule of Insurance. A separate Schedule of Insurance applies to each new Coverage Period. Eligible Aggregate Expenses are benefits which We have determined to be properly Paid by You. Such expenses must be Paid on behalf of a Covered Person or Covered Dependent according to the terms of the Benefit Plan. These expenses are subject to all of the terms, conditions and limitations of this Policy, including the Exclusions and Limitations section of this Policy and the Schedule of Insurance. Expenses Incurred under a Prescription Drug Plan will be included as Eligible Aggregate Expenses only if Prescription Drug Plan is shown as included on the Schedule of Insurance. All claims are subject to Our Claim Audit per the Miscellaneous Provisions of this Policy.

Eligible Aggregate Expenses do not include:

1. Benefits payable under any Specific Excess Loss or Excess Loss Insurance issued to You by Us or any other insurer; or
2. Eligible Specific Expenses in excess of the Specific Deductible; or
3. Eligible Specific Expenses in excess of the Specific Deductible for expenses Incurred by any Covered Person or Covered Dependent who is subject to the Adjusted Specific Deductible; or
4. Any other benefits Paid by any other entity providing the same or similar coverage as the Benefit Plan during the Coverage Period.

The Company is not obligated to reimburse expenses which are not considered Medically Necessary; or are Experimental or Investigative procedures which are not recognized by the Food and Drug Administration of the United States Government or other authoritative as generally accepted standards of medical practice.

WHEN BENEFITS WILL BE PAID
Aggregate Excess Loss benefits will be paid after the end of the Coverage Period if the deductible described below is satisfied, subject to all terms, conditions and limitations of this Policy. Upon acceptance of Proof of Loss, We will pay benefits to You for Eligible Aggregate Expenses that exceed the Annual Aggregate Deductible for claims Paid that are:

1. Incurred while the Benefit Plan is in force;
2. Paid according to the terms of the Benefit Plan; and
3. Incurred and Paid during the Coverage Period shown on the Schedule of Insurance.

AMOUNT OF BENEFIT PAYABLE
The Aggregate Excess Loss benefit payable shall be equal to the product of:

1. The Aggregate Benefit Percentage, multiplied by
2. The amount of Eligible Aggregate Expenses Paid which exceeds the Annual Aggregate Deductible for the Coverage Period.

The Aggregate Benefit Percentage is shown on the Schedule of Insurance. In no event will We pay more that the Aggregate Limit of Liability as shown on the Schedule of Insurance.

ANNUAL AGGREGATE DEDUCTIBLE
The Annual Aggregate Deductible for a Coverage Period will be the greatest of:

1. An amount equal to the sum of 12 monthly amounts for the Policy Period where such monthly amount is equal the Monthly Aggregate Attachment Point, as shown on the Schedule of Insurance, multiplied by the number of Covered Persons covered under the Benefit Plan on the first day of each month of the Policy Period. If the Policy Period is less than 12 months, the sum of monthly amounts for the months completed will be divided by the number of months completed in the Policy Period and multiplied by 12. If the number of Covered Persons decreases, the decrease in the number of Covered Persons may not be reduced by more than 5% of the previous month's Covered Persons. During any period in which any of Your employees are absent from work due to a strike, lock out, or work stoppage, the number of Covered Persons will remain at the same level as for the month before the disruption began.

If this Policy terminates during a Policy Period, the deductible will be based on a Policy Period of 12 full months. The Monthly Aggregate Attachment Point, multiplied by the sum of the monthly amounts for the months completed will be divided by the number of months completed in the Policy Period and multiplied by 12. Calculation of the deductible in this manner will not affect the termination of Aggregate Excess Loss benefits on the date this Policy actually terminates; or

2. The Monthly Aggregate Attachment Point multiplied by 2,286, multiplied by 12; or

3. The Monthly Aggregate Attachment Point multiplied by 85% of the number of Covered Persons under the Benefit Plan at the beginning of the eleventh month of the prior Policy Period, multiplied by 12; or

4. The Minimum Annual Aggregate Deductible shown on the Schedule of Insurance.

TO WHOM BENEFITS WILL BE PAID
Aggregate Excess Loss benefits will be paid to You. We will not make payment directly to any Covered Person, Covered Dependent, Provider or anyone else. You shall not represent that We are the insurer of benefits provided by the Benefit Plan.

SECTION IV – PREMIUM AND CLAIM PROVISIONS

PAYMENT OF PREMIUMS: The premium rates and due dates for coverage provided under this Policy are shown in the Schedule of Insurance. The initial premium is due on the Effective Date of this Policy and subsequent premiums are due as specified on the Schedule of Insurance. For coverage under this Policy to remain in effect, each premium must be paid on or before its due date. You must pay the premium for this Policy to Us on or before the Premium Due Date.

GRACE PERIOD: A Grace Period of 31 calendar days will be allowed for the payment of each premium due after the first premium has been paid. This Policy will continue in force during the Grace Period. If a premium is not paid by the end of the Grace Period, this Policy will automatically terminate as of the last date for which premium was paid. We may deduct the amount of any premium due for a Grace Period from any benefit We may owe You under this Policy.

PREMIUM RATES: The initial premium rates are stated in the Schedule of Insurance. We may change the premium rates:

1. Whenever You amend or materially change the Benefit Plan; or
2. When this Policy is amended; or
3. On any Premium Due Date after the first Policy Period after We provide You with 45 days advance written notice.

PREMIUM DATA: You must provide a report to Us with each premium payment, in a form satisfactory to Us, that lists:

1. The number(s) of participants in the Benefit Plan on the first day of the Benefit Month, as categorized under Coverage Description on the Schedule of Insurance; and
2. The amount of premium paid.

You acknowledge and understand that We use such premium data reports solely to process premium. Such premium data reports do not replace any report required, or which may be required, under the Reporting Requirements provision of this Policy.

PROOF OF LOSS: You or the Claim Administrator must request payment and provide complete and accurate Proof of Loss, in form and content acceptable to Us, to support a claim within [180] calendar days after the end of the Coverage Period. We may deny any claim(s) received after the end of the 180 calendar day period. However, any claim that is either submitted, or that remains incomplete, more than 180 days after the termination of this Policy will be denied. In no event will the Company be liable for any claims if documentation acceptable to the Company to substantiate such claims is not received within the period of time specified above.

PAYMENT OF CLAIMS: All benefits payable under this Policy will be paid to You and to no one else. In no event will the Company be liable for any claims which are not Incurred or Paid by the Policyholder within the Coverage Period indicated in the Schedule of Insurance.

In the event charges for Eligible Expense Incurred and Paid by the Policyholder on behalf of any Covered Person or Covered Dependent during the Coverage Period stated in the Schedule of Insurance exceed, or are expected to exceed, the Specific Deductible, the Company shall have the right to appoint an administrator to represent its interest in the ongoing administration of the claim. Any cost incurred for the Company's administration of the claim shall be borne by the Company.

The Policyholder must cooperate with the Company or its representative in a timely manner in the administration, investigation and the settlement of any claim payable under this Policy.

OFFSET: The Company has the right to offset any claims payable to the Policyholder under this Policy against premiums due and unpaid by the Policyholder. This right will not prevent the termination of this Policy for non-payment of premium under SECTION VII – TERMINATION AND RENEWAL PROVISIONS.

REPORTING REQUIREMENTS: You are required to provide periodic reports to Us as described below.

For Specific Excess Loss benefit reporting, You or the Claim Administrator must give notice to Us when the total amount of Eligible Specific Expenses Paid by You for a Covered Person or Covered Dependent equals or exceeds 50% of the Specific Deductible, or has the potential to exceed 50% of the Specific Deductible. Your failure to provide prompt notice may result in an adjustment of any Specific Excess Loss benefits payable to You, if any, to reflect any savings We could have obtained had prompt notice been given. Similar reporting shall be required for any Eligible Expenses Paid for a Covered Person or Covered Dependent subject to a Specific Adjusted Deductible as shown on the Schedule of Insurance.

You or the Claim Administrator are required to provide Us with notice of any potential Specific Eligible Excess Loss claim within 31 days of the date:

1. Covered Person's or Covered Dependent's Eligible Incurred Expenses exceed 50% of the Specific Deductible; or
2. You or the Claim Administrator or Your medical management, utilization review, Prescription Drug Plan, precertification vendors, or any other party acting on Your behalf, are notified that a Covered Person or Covered Dependent has been diagnosed with, or treated for, a serious condition which, if Paid, would result in an Eligible Expense under this Policy that would equal or exceed 50% of the Specific Deductible.

For Aggregate Excess Loss benefit reporting, You or the Claim Administrator are required to provide Us with a monthly report that lists:

1. The total amount of Eligible Aggregate Expenses Incurred within the Coverage Period by any Covered Person or Covered Dependent and Paid by or on behalf of You during that Benefit Month; and
2. The number(s) of participants in the Benefit Plan on the first day of the Benefit Month, as categorized under Benefits To Be Covered as shown on the Schedule of Insurance. The Aggregate Report must be provided to Us within 31 days after the end of each Benefit Month.

SECTION V – EXCLUSIONS AND LIMITATIONS

Eligible Expenses shall not include the following, whether or not such expenses are covered under the Benefit Plan, unless otherwise specifically included in the Schedule of Insurance:

1. Any portion of an expense which You are not obligated to pay under the Benefit Plan, or which is reimbursable to You pursuant to or because:

    a. Another group health benefit program is or may be liable;
    b. The Covered Person or Covered Dependent is covered under, or eligible for, Medicare, the Railroad Retirement Program, or any similar federal, state or local program or statute;
    c. Services or supplies for the treatment of an occupational injury or sickness which are paid under any Workers' Compensation, occupational disease law or similar law whether or not the Covered Person claims his or her rights to such benefits; or
    d. Any coordination of benefits or non-duplication of benefits provision of the Benefit Plan.

2. Benefits Paid under the Benefit Plan which are in excess of Reasonable and Customary charges or result from any treatment, service or supply that is not Medically Necessary;

3. Expenses associated with the administration of the Benefit Plan including, but not limited to, claim payment fees, PPO access fees, premium functions, medical review and consultant fees unless otherwise payable under the Reimbursement of Certain Fees provision, any tax liability, interest, or penalty imposed by any regulatory or taxing authority;

4. Expenses Paid by You or the Claim Administrator relating to any litigation concerning the Benefit Plan, including, but not limited to, attorneys' fees, legal or investigative expenses, expert fees, extra-contractual damages, compensatory damages and punitive damages;

5. Benefits Paid for expenses Incurred outside of the U.S. except in emergency situations. Emergency situations are defined as instances of a serious injury, the onset of a serious condition which requires immediate medical intervention to prevent death, or a serious impairment of health. Emergencies do not include elective care or care of minor illness or injury;

6. Expenses which are Experimental or Investigational;

7. Benefits Incurred by a Covered Person or Covered Dependent whose Known medical conditions were not accurately Disclosed to Us by You, Your designated representative or Claim Administrator at the time of Disclosure, the initial underwriting, the Effective Date or the renewal of this Policy following the end of any Policy Period.

SECTION VI – MATERIAL CHANGE PROVISIONS

MATERIAL CHANGE: You must give Us written notice within 31 days of any Material Change to the Benefit Plan which in Our reasonable judgment may have a material adverse financial, economic or other effect on Our liability under this Policy. **Failure to provide such notice could result in termination of this Policy or denial of benefits payable on behalf of a Covered Person or Covered Dependent**. Notice must be provided to:

PartnerRe America Insurance Company
Underwriting Department
450 Sansome Street, 4th Floor
San Francisco, CA 94111

A Material Change includes, but is not limited to, a change to, or of, any of the following:

1. The information disclosed by You upon which Our assessment of risk was based;
2. The Benefit Plan;
3. The Claim Administrator or Managed Care Network;
4. An increase or decrease in the number of Covered Persons and Covered Dependents that exceeds 15% of the current number covered under the Benefit Plan;
5. The insolvency or inability to pay obligations of You or the Benefit Plan; or
6. A merger, acquisition or similar transaction involving You or any of Your affiliates or subsidiaries.

If You amend the Benefit Plan, Managed Care Network, Claim Administer or change Your business so as to result in a material adverse financial, economic or other effect on Our liability or risk under this Policy, We will have the right to (i) recalculate Monthly Expected Claims and Specific Excess Loss Premium Rates as shown on the Schedule of Insurance and continue this Policy, or (ii) terminate this Policy in accordance with the Policy Termination provision of this Policy. If We elect to continue this Policy, the new Monthly Expected Claims and Specific Excess Loss Premium Rate will be effective on the date specified by Us.

BENEFIT PLAN AMENDMENTS: You must give Us written notice of any amendment to the Benefit Plan at least 31 days prior to the effective date of the amendment. If the amendment changes the benefits under the Benefit Plan, Your Monthly Expected Claims and Specific Excess Loss Premium Rate as shown on the Schedule of Insurance will be recalculated. Any revision to Your Monthly Expected Claims or Specific Excess Loss Premium Rate due to an amendment will become effective on the effective date of the amendment. If We do not receive notice from You prior to the effective date of the Benefit Plan amendment, We will determine if benefits are payable based on Your Monthly Expected Claims and Specific Excess Loss Premium Rate calculated (1) without the amendment or (2) with the amendment, whichever is greater.

SECTION VII – TERMINATION AND RENEWAL PROVISIONS

POLICY TERMINATION: This Policy will terminate on the earliest of the following circumstances:

1. If You fail to pay the required premium by the end of the Grace Period, this Policy will terminate in accordance with the Premiums provision of this Policy.

2. If the Benefit Plan terminates, this Policy will terminate on the date the Benefit Plan terminates.

3. If You fail to maintain a minimum of 100 Covered Persons covered under the Benefit Plan at any time during the Policy Period, We may elect to terminate this Policy at the end of the first month during which there are less than 100 enrolled Covered Persons.

4. This Policy will terminate at the end of the Policy Period unless You and We agree in writing to renew this Policy.

5. If You or the Claim Administrator fail to satisfy any of its obligations under this Policy, We reserve the right to terminate this Policy by giving You 60 days advance written notice.

We will not refund any portion of the premium paid by You if this Policy terminates during a Policy Period.

If this Policy terminates prior to the end of the Policy Period, the Policy Period will be revised to end on the date of the effective date of the termination of the Policy and any specified number of months of the Coverage Period as shown on the Schedule of Insurance will be reduced by the number of months by which the original Policy Period was shortened.

REQUIREMENTS TO RENEW COVERAGE: You may request this Policy be renewed. This Policy may not be renewed unless We approve Your request for renewal and all of the following conditions are satisfied:

1. The number of Covered Persons enrolled in the Benefit Plan must equal or exceed the minimum enrollment shown on the Schedule of Insurance;

2. You must furnish Us with information showing monthly Paid claims and enrollment data, organized by Benefits To Be Covered;

3. You must furnish Us with Claim Information and Disclosure for any Covered Person or Covered Dependent meeting the definition of Serious Claim;

4. You must furnish Us with a census of all Covered Persons and Covered Dependents;

5. You must furnish Us with a summary of the number of Covered Persons by residence zip code; and

6. You must furnish Us with Your current Benefit Plan and any anticipated changes; and

7. You must furnish Us with a summary report of Your Managed Care Networks(s), setting forth the average hospital discounts per day.

Our approval to renew the Policy may be subject to terms, conditions and limitations. If we renew this Policy, We will furnish You with a revised Schedule of Insurance.

SECTION VIII – GENERAL PROVISIONS

ASSIGNMENT: You may not assign, pledge or transfer, in whole or in part, this Policy or any interest therein or any benefits payable hereunder without Our prior written consent. Any such action will be void and of no effect.

CLERICAL ERROR: No clerical error, whether made by You, the Claim Administrator, or Us, that relates to recordkeeping, reporting, payment of benefits or premiums, will invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. However, upon discovery of such error or delay an equitable adjustment of premiums or benefits will be made. In the event that claims data and/or enrollment information furnished to Us is missing or incorrect, We have the right to recalculate the Monthly Expected Claims and Specific Excess Loss Premium Rate as shown on the Schedule of Insurance using the corrected information.

CONFORMITY WITH STATE STATUTES: Any provision of this Policy which, on the Effective Date of this Policy, conflicts with any law of the state where this Policy is delivered, shall be deemed to be automatically amended to conform to the minimum requirements of such law.

ENTIRE CONTRACT: The entire contract between You and Us consists of:

1. The Policy;
2. Your Excess Loss Insurance Application (a copy of which is attached to this Policy when issued);
3. The Schedule of Insurance; and
4. The Claims Disclosure Statement (a copy of which is attached to this Policy when issued); and
5. Any Endorsements included with and made part of this Policy.
6. Administrative Manual

All statements made by You in the absence of fraud shall be deemed representations and not warranties. No such statement shall be used in defense to a claim under this Policy unless it is contained in the written Excess Loss Insurance Application or Claims Disclosure Agreement and is signed by You or is attached to this Policy.

INDEMNIFICATION: You agree to indemnify, defend and hold Us harmless from any liability, damages of any kind, interest, penalties, or expenses (including without limitation, attorney fees) arising from, relating to or concerning in any way whatsoever, any dispute or legal action by or involving a Covered Person, Covered Dependent, or a provider of services to a Covered Person or a Covered Dependent.

LEGAL ACTION: Legal action may not be taken to receive benefits until 60 days after the date Proof of Loss is received in accordance with the terms of this Policy. Legal action must be taken within 3 years after the date Proof of Loss is submitted.

This Policy is deemed made in the state in which it was delivered, as shown on the face page of this Policy. Any lawsuits brought by either party against the other related to this Policy must be brought in that state and settled according to its laws.

A clerical error is a mistake in performing a clerical function, such as typing, but does not include Your acts or Your failure to comply with the provisions of the Benefit Plan or this Policy. This paragraph shall not be construed in any way to impair Our rights under the Misrepresentation provision of this Policy.

MISREPRESENTATION/MISSTATED DATA: The Company has relied upon underwriting information provided by You, the Claim Administrator or other party acting on Your behalf. If:

1. You make any material misstatement, omission or misrepresentation, whether intentional or unintentional, in the information or documentation that You, the Claim Administrator or any other party acting on Your behalf provide to Us, and which We rely upon during the underwriting of this Policy; or
2. After this Policy is issued, We learn of any expense or claim that was Incurred or Paid, but not reported to Us during the underwriting of this Policy, then, in such event:

We reserve the right to deny any such claim, rescind this Policy or to revise the premium rates, deductibles, and terms, conditions and limitations of this Policy in accordance with Our underwriting practices in effect at the time the Policy was underwritten. Any such revisions may be made retroactive to the Effective Date.

NO THIRD PARTY BENEFICIARY: The Policy is issued by Us to You, and to no one else. The provisions of this Policy are not intended to confer any benefits upon any person or entity other than You, and no person or entity is an intended third party beneficiary of this Policy.

NON-PARTICIPATING: This Policy does not pay a dividend and shall not be entitled to share in Our surplus earnings.

POLICY AMENDMENTS/CHANGES: We may amend this Policy on any renewal date. No change in this Policy is valid unless it is approved and signed by one of Our designated corporate officers or an Assistant Secretary. Agents or brokers do not have the right to change this Policy, waive any of its provisions, or bind Us in any way.

PREPARATION OF POLICY: As You and We are both sophisticated entities, in the event of an ambiguity in or dispute regarding the interpretation of this Policy, interpretation of this Policy shall not be resolved by any rule providing for interpretation against the party who causes the uncertainty or against the drafter, and both You and We expressly agree that in the event of an ambiguity or dispute regarding the interpretation of this Policy, the Policy will be interpreted as if both You and Us had fully participated in the negotiation and preparation of this Policy.

REIMBURSEMENT: Your rights under the Benefit Plan to recover sums Paid during the Coverage Period on behalf of a Covered Person or Covered Dependent, are assigned by You to Us to the extent of any benefits paid under this Policy. You agree to promptly recover such sums, at Your cost, by initiating legal action or other effective means. Within 10 days of initiating any action or other means for recovery, You shall notify Us, and We shall have the right to intervene in any suit or other proceeding to protect Our reimbursement rights. We shall be entitled to receive full reimbursement to the extent of benefits paid under this Policy.

REINSTATEMENT: If this Policy is terminated for non-payment of premium, We reserve the right to reinstate it as of the date it terminated upon payment of all outstanding premium. You must furnish all information requested by Us before We will consider reinstating this Policy. Reinstatement may be subject to terms, conditions and limitations.

YOUR BANKRUPTCY OR INSOLVENCY: Eligible Expenses will not be affected by Your bankruptcy or insolvency. In the event of Your bankruptcy or insolvency, subject to the terms, conditions and limitations of this Policy, We may pay to Your receiver, trustee, liquidator or legal successor amounts otherwise payable under this Policy. We will make such payments only if You have paid all required premiums and have Paid all eligible expenses under the Benefit Plan, and have complied with all Your obligations under this Policy. Nothing in this section shall increase Our liability beyond that which would have existed had You not become insolvent or bankrupt.

SECTION IX – MISCELLANEOUS PROVISIONS

CLAIM ADMINISTRATOR RESPONSIBILITIES: The Claim Administrator acts on Your behalf and as Your agent. If claims are Paid by a Claim Administrator, We may require that You provide Us with any information possessed by the Claim Administrator that will assist Us in administering this Policy.

For Specific Excess Loss Insurance this includes but is not limited to:

1. When expenses, Paid and/or pending, for a Covered Person or Covered Dependent exceed 50% of the Specific Deductible;
2. Notification, regardless of the deductible amount, of any potential or planned organ transplant;
3. Claim or claim report for any Covered Person or Covered Dependent who exceeds the Specific Deductible applicable to such Covered Person or Covered Dependent;
4. Transplant contracts, case management notes, and any other documentation that may be needed in order for Us to properly determine how the Claim Administrator adjudicated the claim. If such items are considered proprietary by the Claim Administrator a written statement from the Claim Administrator providing the substance of the requested items may be accepted; and
5. Documentation of any Experimental, Investigational or Medical Necessity review performed by the Claim Administrator in the determination of the eligibility of benefits paid under the Benefit Plan.

Similar reporting shall be required for any Eligible Expenses Paid for a Covered Person or Covered Dependent subject a Specific Adjusted Deductible as shown on the Schedule of Insurance.

If Aggregate Excess Loss Insurance is included, the Claim Administrator's Responsibilities also include, but are not limited to, submitting a monthly report to Us in a format acceptable to Us showing the total amount of claims Paid and enrollment numbers detailed by coverage type.

You are solely responsible for the actions of the Benefit Plan administrator, the Claim Administrator and any other agent of Yours. The Claim Administrator acts on Your behalf and not on Our behalf. The Claim Administrator is not Our agent. We are not responsible for any compensation owed to, or claims by, the Claim Administrator or other agents for services provided to, or on behalf of, You or the Benefit Plan. This Policy does not make Us a party to any agreement between You and the Claim Administrator, nor does it make the Claim Administrator a party to this Policy.

CLAIM AUDIT: We may periodically examine any of Your or the Claim Administrator's records relating to the benefits under this Policy and any claims filed under the Benefit Plan. We have the right to audit all claims with respect to Eligible Expenses Paid under the Benefit Plan, in the event a claim for benefits is made under this Policy.

INDEPENDENT REVIEW ORGANIZATION EXTENDED BENEFIT: In the event Eligible Expenses are Paid for a Covered Person or Covered Dependent due to a reversal by an Independent Review Organization of a previous denial of such expenses, and such covered expenses are then Paid after the Coverage Period, the Coverage Period to pay such expenses will be extended for a period not to exceed 12 months. We will consider the date the claim was denied as the "Paid" date under this Policy, provided:

1. Such expenses are not eligible under any other coverage; and
2. Such expenses are otherwise payable under the terms of this Policy.

When Eligible Expenses are Paid pursuant to the terms, conditions and limitations of this Independent Review Organization Extended Benefit, such expenses will relate back to the Coverage Period in which they were Incurred and will be excluded from any other Coverage Period.

If You terminate this Policy for any reason prior to 12 months following the Effective Date shown on the Schedule of Insurance, this provision will not apply.

REIMBURSEMENT OF CERTAIN FEES: Eligible Expenses will also include the following fees Incurred and Paid by the Policyholder, if approved **in advance** of claim by Us:

1. Hospital bill audits;
2. Access to non-directed provider networks;
3. Access to transplant provider networks;
4. Negotiation of out-of-network bills; and
5. Cost Containment Vendors.

Such fees shall be considered Eligible Expenses only if You can demonstrate to Us that the services that generated the fees resulted in a cost savings to the Benefit Plan and Us. If You can demonstrate such a cost savings, We will consider such fee an Eligible Excess Loss Expense, up to 25% of such cost savings per Covered Person or Covered Dependent.

STATE ASSESSMENT LOADS: State and Federal laws may assess excess loss insurance carriers based on the number of that state's residents who are covered under excess loss policies. We shall have the right to increase premium rates to cover expected state assessment costs, based on the most current applicable assessment rates.

STATE HEALTH CARE SURCHARGES: If You pay a state health care surcharge in connection with the payment of Eligible Expenses, the health care surcharge shall be considered an Eligible Expense provided that the charges were submitted and duly noted as such. Penalties or fines associated with the health care surcharge or the underlying expenses will not be considered Eligible Expenses.

PartnerRe

CLAIMS DISCLOSURE STATEMENT

Policyholder: Weslaco ISD

Effective Date: September 1, 2016

This Claims Disclosure Statement ("Statement") must be completed and returned to PartnerRe America Insurance Company ("PartnerRe") within five (5) days of signing the Application. Prior to completing this Statement, please perform a diligent review for potential Serious Losses by consulting with your administrator, utilization review and case management firm(s) to review claim information including, but not limited to, pre-certification information, disability and/or utilization review data, case management records, hospital inpatient logs and transplant waiting list(s).

Serious Losses mean any potential Covered Person expected to incur claims that may reasonably be assumed will exceed 50% of the Specific Deductible based on their:

1. Diagnosis;
2. Current condition or hospital confinement status;
3. Potential for transplant; or
4. Potential for receiving specialty drugs, blood factor products or blood derivatives.

Serious Losses ***known*** by You, the Policyholder, either internally or from any delegated authority such as an administrator, utilization review or case management company, as of the date the Application is signed, will be excluded from coverage unless Disclosed to and accepted by PartnerRe.

Disclosed means PartnerRe's receipt, review and acceptance of the following information:

1. Member ID/Name (or other unique identifier) and Date of Birth;
2. Admission date and estimated discharge date, if applicable;
3. Diagnosis, current status, and treatment plan;
4. Expenses incurred to date & estimated expenses to be incurred/paid within the Policy Period; and
5. Additionally, for Covered Persons identified as receiving, or having the potential to receive, specialty drugs, blood factor products or blood derivatives please provide:
    - If member is receiving product prophylactically or on an as needed basis;
    - Product name, dosage, frequency and cost per treatment;
    - Site of administration (i.e. Inpatient, Outpatient, Physician office, home) and
    - Anticipated hospital admissions or planned surgeries.

It is Your duty to provide current information for Covered Persons who may have been included in the information exchanged during the underwriting process and who meet the definition of Serious Losses at the time of signing the Application. We retain the right to adjust premium rates, deductibles or coverage terms if You fail to provide disclosure information.

Policyholder Attestation:

Based upon the review of claim information, please confirm one of the following statements:

☐ Yes, I have Serious Losses to Disclose. Please refer to: _____

☒ No, I have no Serious Losses to Disclose. All applicable claim info was issued during best and final offer.

After diligent review, I hereby represent and warrant that this Claims Disclosure Statement is complete and accurate to the best of my knowledge and belief and that nothing has been intentionally omitted. It is acknowledged that PartnerRe America Insurance Company retains the right to exclude or otherwise adjust terms on potential Covered Persons regarding this Disclosure. Should PartnerRe require additional information on any Covered Person disclosed, we agree to provide access to that information so PartnerRe may evaluate the risk and provide final terms.

Policyholder Signed By:

Its Corporate Officer or Authorized Representative

September 12, 2016
Date

Director of Employee Benefits
Title

If this Claims Disclosure Statement or any attachments contains personal and Protected Health Information under HIPAA it should only be transmitted in a HIPAA compliant medium.
DO NOT SEND VIA AN UNSECURED E-MAIL TRANSMISSION.

Accepted by PartnerRe America Insurance Company:

☒ Yes ☐ No, the following Special Conditions of Coverage will apply:

Underwriter

9/27/16
Date

Special Conditions of Coverage:
N/A

PartnerRe

Excess Loss Insurance Application

PartnerRe America Insurance Company
Wilmington, DE
NAIC# 11835

Mailing Address:
450 Sansome St., 4th Floor
San Francisco, CA 94111
800 385 6802

The Applicant hereby applies for the Excess Loss Insurance Policy.

1. POLICYHOLDER: Weslaco ISD
   Principal Address: 319 West Fourth Street
   Weslaco, TX 78599

   Are subsidiary or associated entities to be included? ☐ Yes ☒ No
   If Yes, please provide a list of their Full Legal Name(s) and Address(es).

2. POLICY PERIOD: Effective Date: September 01, 2016
   Termination Date: September 01, 2017

3. POLICYHOLDER INFORMATION:

   i. Standard Industrial Classification (SIC): 8211-8299

   ii. ☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☒ Other

   If other, please specify: School District

   iii. Nature of Policyholder's Business: Educational Services

4. CLAIM ADMINISTRATOR: Frates Benefit Administrators
   Address: 13439 Broadway Extension, Suite 110
   Oklahoma City, OK 73114

5. EXCESS LOSS INSURANCE:

   a. Specific Excess Loss Insurance: ☒ Yes ☐ No

      i. Specific Deductible: $125,000 per Individual
      The Plan Benefits for member #31502171F(01) is Medical Only (rx is excluded from stop loss).
      Claims for individuals subject to the Adjusted Specific Deductible that exceed the Specific Deductible are excluded under any Aggregate Excess Loss Insurance.

ii. Coverage Period: Incurred in 12 months and Paid in 15 months

b. Aggregate Excess Loss Insurance: ☒ Yes ☐ No

i. Monthly Aggregate Attachment Point: $698.94 per Composite per month

ii. Coverage Period: Incurred in 12 months and Paid in 15 months

The coverage afforded by this Application is based upon the Excess Loss Quotation dated 9/12/2016 attached hereto, incorporated herein, and is conditioned upon receipt, review and acceptance by PartnerRe America Insurance Company ("PartnerRe"), on or before 09/26/2016, of all outstanding information as detailed in Special Notations section of the quotation. Additional underwriting adjustments, including changes to terms, premium or specific deductibles on certain individuals, may be required.

This Application is based upon claim details, enrollment, eligibility, Benefit Plan and other information provided by Applicant to PartnerRe. Any known material change in such information must be reported to and agreed upon by PartnerRe prior to coverage becoming effective.

The coverage afforded by this Application is to be effective from 12:01 A.M. standard time on the Effective Date stated above at the Policyholder's address, provided the first month's premium is paid in full and that the Claims Disclosure Statement and this Application are accepted and approved by PartnerRe. The coverage afforded by this Application is subject to all terms and conditions of the Policy in current use by PartnerRe. This Application and Claims Disclosure Statement will become a part of the Policy when issued.

This Application assumes the Producer/Agent of Record is duly licensed as required by law and has been appointed with PartnerRe America Insurance Company in the state in which the Policyholder is located and the Policy is to be delivered.

By signing this Application and the Claims Disclosure Statement, the Applicant represents that all statements, answers and information provided to PartnerRe are complete and true to the best of its knowledge. Applicant further acknowledges and agrees (i) that such statements, answers and information provided and in the Claims Disclosure Statement, together with a copy of the Benefit Plan and other information attached to this Application or furnished to PartnerRe, are submitted by the Applicant as an inducement to and will be relied upon by PartnerRe in underwriting this risk and determining whether to accept this Application and issue the policy being applied for; (ii) if such statements, answers and information is/are incomplete or untrue and such incompleteness or falsity is material to the risk to be insured by PartnerRe, any policy issued by PartnerRe may be rescinded and/or any benefits that might otherwise be payable thereunder may be denied; and (iii) the Applicant has fully read and understands this completed Application and the Claims Disclosure Statement.

I hereby agree to the terms as stated above and warrant that I am duly authorized to execute this acceptance:

Applicant Signed By:

Michael De La Rosa — 9-12-16

Its Corporate Officer or Authorized Representative — Date

Director of Employee Benefits — 74-6002548

Title — FEIN#

Accepted by PartnerRe America Insurance Company:

[signature] — 9/27/16

Date

AVP UNDERWRITER

Title

INSURANCE FRAUD WARNING

Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading, is guilty of insurance fraud and is subject to criminal and/or civil penalties.

EMPLOYER EXCESS LOSS QUOTATION

PartnerRe

Policyholder:	***PartnerRe America Insurance Company ("Company")***
Weslaco ISD	Wilmington, DE (NAIC# 11835)
319 West Fourth Street	450 Sansome Street, 4th Floor
Weslaco, TX 78599	San Francisco, California 94111

Policy Period: September 01, 2016 - September 01, 2017

PartnerRe America Insurance Company
Ratings: Standard & Poor's: A+ Moody's: A1 A.M. Best: A Fitch: AA-

Claim Administrator:	Frates Benefit Administrators
Status:	**Pending Approval**
Preferred Provider Network:	First Health
Benefit Plan Basis:	**Current Plan**
Employees:	2,286
Total Employees:	2,286
Retirees:	**Not Included**
	Option 2
Commission %:	0%
	SPECIFIC STOP LOSS
Specific Deductible:	**$125,000**
Specific Annual Maximum:	**Unlimited**
Specific Lifetime Maximum:	**Unlimited**
Specific Benefit %:	100%
Coverage Period:	**12/15**
Plan Benefits Included:	**Medical & Rx**
Aggregating Specific Deductible:	**$272,719**
Monthly Specific Premium Rates	
Employee:	**$55.66**
Estimated Premium Per Policy Period:	$1,526,865
Minimum Premium:	$1,297,835
	AGGREGATE STOP LOSS
Aggregate Limit of Liability:	**$1,000,000**
Loss Limit Per Person:	$125,000
Aggregate Attachment Point %:	**125%**
Aggregate Benefit %:	100%
Coverage Period:	**12/15**
Plan Benefits Included:	**Medical & Rx**
Monthly Aggregate Attachment Points	
Employee:	**$698.94**
Minimum Aggregate Attachment Point:	$19,173,322
Aggregate Composite Premium Rate:	**$0.49**
Estimated Premium Per Policy Period:	$13,329

Special Notations

This Quotation is tentative and subject to receipt, review and acceptance of the following information by the Company, which is critical to coverage structure and premium rating. Additional underwriting adjustments, including changes in terms and higher specific deductibles on certain individuals, may be required.

1. Actively at Work is waived with receipt and acceptance of the PartnerRe Claim Disclosure Statement.
2. Claim Administrator Questionnaire and Approval
3. Completion and signature of the Application.
4. Finalized Plan Document, revisions or amendments to be provided and approved.
5. This Quotation assumes that the Agent/Broker is operating under the appropriate license and has been appointed with the Company in the state in which the risk is located (the policy is delivered).
6. This Quotation is subject to cancellation or revision prior to the binding of coverage.
7. This Quotation is subject to the verification and approval of the Policyholder against the economic and trade sanction watch lists enforced by the Office of Foreign Assets and Control (OFAC).
8. The Plan Benefits for 31502171F(01) is Medical Only (rx excluded from stop loss)

To ensure a smooth transition and to maximize cost containment initiatives, PartnerRe offers an implementation meeting to each new client. Our goal is to understand the specific needs of the Policyholder and to offer solutions that meet their unique requirements.

Terms presented in this Quotation expire on: **September 13, 2016**

Brian Reule
Managing Underwriter, AVP
PartnerRe America Insurance Company
Direct: 1 815 307 1665
Fax: 1 913 871 7201
Brian.Reule@PartnerRe.com

PartnerRe

Aggregated Specific Deductible Endorsement

PartnerRe America Insurance Company
Wilmington, DE

Mailing Address:
450 Sansome Street, 4th Floor
San Francisco, CA 94111
800 385 6802

Endorsement No.: ONE

Effective Date: September 1, 2016

Policyholder: Weslaco ISD

Attached to and forming a part of Policy No.: P0312973101

This Endorsement modifies insurance provided under the Excess Loss Insurance Policy. It is hereby understood and agreed that the following changes are made and incorporated into the Policy:

An additional deductible of $272,719 must be met before the Company will reimburse the Policyholder under the Specific Excess Loss Insurance coverage. When charges for Eligible Specific Expenses for any Covered Person or Covered Dependent that are Incurred and Paid during the Coverage Period stated in the Schedule of Insurance exceed the Specific Deductible [or Adjusted Specific Deductible, if applicable,], the excess loss will be applied against the Aggregated Specific Deductible ("ASD"). Such excess losses will be aggregated with respect to all Covered Persons and Covered Dependents. Once the aggregated excess losses for all Covered Persons and Covered Dependents exceed the Aggregated Specific Deductible, losses with respect to any one Covered Person or Covered Dependent, which subsequently exceed the Specific Deductible [or Adjusted Specific Deductible, if applicable], will be reimbursed by Us.

We reserve the right to recalculate the Aggregated Specific Deductible, referred to above for the Policy Period if there is more than a 10% variance between the number of Covered Persons on any premium due date and the number of Covered Persons on the covered Benefit Plan on the Effective Date of this Policy.

The Company will recalculate the Aggregate Specific Deductible referenced above retroactive for the Policy Period based on the actual number of Covered Persons and Covered Dependents per each month of the Policy Period. The final Aggregated Specific Deductible is an amount equal to the greater of the ASD PEPM as stated in the Schedule of Insurance per each Covered Person per each month of the Policy Period or the Minimum ASD shown above.

All Eligible Expenses in excess of the Specific Deductible [or Adjusted Specific Deductible, if applicable, shown on the Schedule of Insurance shall be excluded from Eligible Aggregate Expenses under any provision of this Policy relating to Aggregate Excess Loss Insurance.

All other terms, conditions and limitations of the Excess Loss Insurance Policy apply to this Endorsement.

In the event of a conflict between the terms, conditions and limitations of this Endorsement and the Excess Loss Insurance Policy, this Endorsement will control.

This Endorsement is made part of the Policy to which it is attached.

IN WITNESS WHEREOF, the Company has caused this Endorsement to be executed and attested and, where required by law, this Endorsement shall not be valid unless countersigned by its duly Authorized Representative(s)

Daniel R. Bolgar
President
PartnerRe America Insurance Company

Thomas L. Forsyth
Corporate Secretary
PartnerRe America Insurance Company

PartnerRe

PARTNERRE AMERICA INSURANCE COMPANY

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Protected Health Information

This notice tells you about the ways in which PartnerRe America Insurance Company may collect, use, and disclose your protected health information, and your rights concerning your protected health information. "Protected health information" is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present, or future physical or mental health or condition, the provision of the health care to you, or the payment for that care.

Your Health Information Rights

Inspect and Obtain Copies. You have the right to inspect or obtain copies of your protected health information records, with some limited exceptions. Usually the records include enrollment, billing, claims payment, or case/medical management records. Your request to inspect and/or obtain a copy of your protected health information record must be made in writing. We may charge a fee for the costs of producing, copying and mailing your requested information, but we will tell you the cost in advance.

Amendment. If you feel that protected health information maintained by us is incorrect or incomplete, you may request that we amend the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request if, for example, you ask us to amend information that was not created by us, or if you ask to amend a record that is already accurate and complete. If we deny your request to amend your protected health information, we will notify you in writing. You have the right to submit to us a written statement of disagreement with our decision and we have the right to disagree with that statement.

Accounting of Disclosures. You have the right to request an accounting of disclosures we have made of your protected health information. The list will not include our disclosures related to your treatment, to payment, to health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes. Your request for an accounting disclosure must be made in writing and must state a time for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2004. Your request should indicate in what form you want to receive the list (for example, on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional lists within the same time period, we may charge for providing the account but we will tell you the cost in advance.

Request a Restriction. You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. We may not agree to your request. If we agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell us what information you want to limit; whether you want to limit how we use or disclose your information, or both; and to whom you want the restrictions to apply.

Confidential Communications. You have the right to request that we use a certain method to communicate with you, such as paper or electronic communication, or that we send information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We

will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Paper Copy of this Notice. You have a right at any time to request a paper copy of this notice, even if you had previously agreed to receive an electronic copy.

Revoke Your Authorization. You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under a health plan.

Unauthorized Access. You are entitled to receive notification of unauthorized access to your PHI. We maintain physical, electronic and procedural safeguards that are compliant with applicable federal and state privacy laws. However, if your PHI is ever compromised, we will notify you of the incident.

Our Responsibilities

PartnerRe America Insurance Company is required by federal and state laws to maintain the privacy of your protected health information, and provide you with this notice about our legal duties and privacy practices with respect to your protected health information. We must follow the terms of this notice while it is in effect. We will notify you if we are unable to agree to a requested restriction. We will accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. We reserve the right to change our privacy practices as outlined in this notice and to make the new provisions effective for all protected health information we maintain. Should we make such a change, we will mail a revised notice to the address you have supplied us. We will not use or disclose your protected health information without your authorization, except as described in this notice.

Uses and Disclosures of Your Protected Health Information

We may use and disclose your protected health information for different purposes. We will keep our uses and disclosures of your personal health information to the minimum necessary to accomplish the purposes for which we are making use or disclosure of the information. The following describe these and other uses and disclosures, together with some examples.

Treatment. We may use and disclose your protected health information to assist your health care providers (doctors, mental health practitioners, pharmacies, hospitals, ambulance services and others) in your diagnosis and treatment. For example, we may disclose your protected health information to a provider to whom you have been referred to ensure that the provider has the necessary information to treat you.

Payment. We may use and disclose your protected health information in order to pay for your covered health expenses. For example, we may use your protected health information to process claims or be reimbursed by another insurer that may be responsible for payment.

Health Care Operations. We may use and disclose your protected health information as necessary to operate our business. Health care operations include rating our risk and determining our premium for your insurance; conducting quality assessment and improvement activities; conducting or arranging for medical review, legal services, audit services, fraud and abuse detection and compliance programs; and business planning and development. We are prohibited from using genetic information for underwriting.

Business Associates. Certain aspects and components of our business are performed through contracts with outside persons or organizations. Examples of these outside persons and organizations include our duly appointed insurance agents, third party administrators, financial auditors, actuarial and underwriting services, reinsurers, legal services, enrollment and billing services, claim payment and medical management services and collection agencies. At times it may be necessary for us to provide your protected health information to one or more of these outside persons or organizations who assist us with our payment or health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Notification. We may use or disclose your name, location and general condition or death to notify, or assist in the notification of (including identifying or locating), a person involved in your care.

Communication with Family. We may disclose your protected health information to a family member, other relative, close personal friend, or any other person you identify if it is relevant to that person's involvement in your health care or the payment related to your health care.

Research. We may disclose your protected health information to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Funeral Directors. We may disclose your protected health information to funeral directors consistent with applicable law to carry out their duties.

Organ Procure Organizations. Consistent with applicable law, we may disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing. We may contact you to provide information or services that may be of interest to you.

Fundraising. We may contact you as part of a fundraising effort.

Plans Sponsors. We may use or disclose protected health information to the plan sponsor of a group health plan.

Food and Drug Administration (FDA). We may disclose to the FDA protected health information relative to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

Workers' Compensation. We may disclose protected health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.

Public Health. As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional Institutions. Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement. We may disclose protected health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision of your protected health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more customers, workers or the public.

Authorization. Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law.

For More Information or to Report a Problem

If you have any questions regarding this notice or need further assistance regarding this notice, please contact us. If you believe that your privacy rights have been violated, you may file a complaint with us and/or the

Secretary of Health and Human Services. You will not be subject to any retaliation for filing a complaint.

Contact Information:
PartnerRe America Insurance Company
Attn: Risk Management & Compliance Officer
7101 College Blvd. Suite 200
Overland Park, Kansas 66210
1-913-871-7200
1-913-871-7201 - Fax

Effective Date

This notice takes effect on September 23, 2013 and will remain in effect until we replace it.

PartnerRe

IMPORTANT NOTICE TO ALL POLICYHOLDERS TEXAS

To obtain information or make a complaint:

You may call PartnerRe America Insurance Company's toll-free telephone number for information or to make a complaint at:

1-800-385-6802

You may also write to PartnerRe America Insurance Company, 450 Sansome Street, 4th Floor, San Francisco, CA 94111

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) 475-1771. Web: http://www.tdi.state.tx.us E-mail: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact PartnerRe America Insurance 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 informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de PartnerRe America Insurance Company's para informacion o para someter una queja al:

1-800-385-6802

Usted tambien puede escribir a PartnerRe America Insurance Company, 450 Sansome Street, 4th Floor, San Francisco, CA 94111

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas; P.O. Box 149104; Austin, TX 78714-9104; FAX # (512) 475-1771. Web: http://www.tdi.state.tx.us E-mail: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con PartnerRe America Insurance Company primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.