Berkshire Hathaway Specialty Insurance

BERKSHIRE HATHAWAY SPECIALTY INSURANCE COMPANY
1314 Douglas Street, Suite 1400, Omaha, NE 68102-1944
(Domiciled in Nebraska)

APPLICATION FOR STOP LOSS INSURANCE

I. GENERAL INFORMATION

PLAN SPONSOR INFORMATION

Full Legal Name of Plan Sponsor (Applicant): City of Burleson

Street Address: 141 W Renfro St

City: Burleson | State: TX | Zip Code: 76028

Original Specific / Aggregate Effective Date:	**Contract Period:**	**Expiration Date:**
01/01/2020	**12 months**	**12/31/2023**

Policy Number	**Effective Date:**	**Deposit Premium** (first month's estimated premium): **$60,856.60**
47-MSL-000338-04	**01/01/2023**	

SUBSIDIARIES, AFFILIATES, DIVISIONS, AND LOCATIONS

Please list all subsidiaries, affiliates, divisions, and their locations to be covered under the Stop Loss Policy.

☒ None

Plan Service Providers

Third Party Administrator(s): United Healthcare | City: Salt Lake City | State: UT

Provider Network(s): UHC Choice Plus | States: Nationwide

Medical Management Vendor(s): United Healthcare | City: Salt Lake City | State: UT

Pharmacy Benefit Manager: OptumRx

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II. SCHEDULE OF BENEFITS

ELIGIBILITY AND ENROLLMENT INFORMATION

Covered Persons under the Plan	Specific Benefit		Aggregate Benefit	
Active	☒Yes	☐No	☒Yes	☐No
Retirees * ☒ Pre-65 ☐ 65 +	☒Yes	☐No	☒Yes	☐No
Disabled	☒Yes	☐No	☒Yes	☐No
Recipients of COBRA continuation coverage	☒Yes	☐No	☒Yes	☐No

*Assumes retirees 65 years and older are Medicare Primary

COVERAGE

Specific Stop Loss Coverage: ☒ **Included** ☐ **Not Included**

Specific Benefit Claims Basis: 60/12, PAID

Eligible expenses incurred from 01/01/2019 through 12/31/2023 and Paid from 01/01/2023 through 12/31/2023.

Specific Benefit Deductible per coverage period $125,000 ☒ Individual

Specific Benefit Annual Maximum Eligible Expense Per Covered Person ☒ No maximum

Specific Benefit Lifetime Maximum Eligible Expense Per Covered Person ☒ No maximum

Specific Benefit Reimbursement Percentage 100%

Specific Benefits	Included
Medical	☒ Yes ☐ No
Prescription Drug Plan	☒ Yes ☐ No

Specific Monthly Premium Rates and Enrollment

	Rate	Covered Units
Composite	$ 172.94	340

Aggregate Stop Loss Coverage: ☒ **Included** ☐ **Not Included**

Aggregate Benefit Claims Basis: 60/12, PAID

Eligible expenses Incurred from 01/01/2019 through 12/31/2023 and Paid from 01/01/2023 through 12/31/2023

Aggregate Benefit Maximum $2,000,000

The Minimum Aggregate Deductible for the Policy Year Is equal to the greater of a) $4,489,102; or b) the amount obtained by multiplying 100% of the Monthly Aggregate Deductible for the first month of the Policy Year by 12 months.

Aggregate Benefit Maximum Eligible Expenses per Covered Person $125,000.

Aggregate Benefit Reimbursement Percentage 100%

Aggregate Enrollment
Covered Benefits

	Medical	Prescription Drug Plan	Dental	STD	Vision	Other
Composite	340	340				
Total	340	340				

Aggregate Deductible Factors (ADF)

Covered Benefits

	Medical	Prescription Drug Plan	Dental	STD	Vision	Other
Composite	$1,100.27	Included in medical				

Aggregate Monthly Premium Rates:

Aggregate rate: $6.05

Note: This proposal includes Plan Mirroring. Final approval is subject to receipt and review of the final SPD.

Optional Endorsements

Renewal Rate Cap 50% with No New Adjusted Specific Deductible ☒ Yes ☐ No

III. THE DISCLOSURE STATEMENT ACKNOWLEDGEMENT

The Company will rely upon the information provided on the Disclosure Statement, which will become part of this Application for the subject Stop Loss Policy, to take underwriting action on all known risks. It is the Plan Sponsor's responsibility, either directly or through their designated representative, to accurately report all claims known as of the date of the Disclosure Statement by making a thorough review of all applicable records. Such records shall include, but are not limited to, historical claims reports, disability records, and current information from administrators, insurers, utilization management companies, managed care companies, and any Agent/Broker of the Plan Sponsor.

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IV. FRAUD WARNINGS

PLEASE READ THE APPLICABLE WARNING BELOW BEFORE SIGNING (REQUIRED BY STATE LAW):

AL: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DC: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FL: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

KY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

LA, RI, and WV: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ME, TN, VA and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NM: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OH: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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Fraud Warnings (continued)

VT: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

GENERAL WARNING (OTHER STATES): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

V. CERTIFICATION AND SIGNATURE

Please return this form and all additional required documentation to Berkshire Hathaway Specialty Insurance Company.

THE COMPLETION OF THIS APPLICATION DOES NOT BIND THE COMPANY TO OFFER, NOR THE APPLICANT TO PURCHASE INSURANCE. IF A POLICY IS ISSUED, IT IS ISSUED IN RELIANCE UPON THIS APPLICATION AND ANY MATERIALS SUBMITTED THEREWITH OR INCORPORATED THEREIN. FURTHERMORE, IT IS AGREED THAT SUCH STATEMENTS, ATTACHMENTS, DOCUMENTS, AND MATERIALS ARE THE BASIS OF THE PROPOSED POLICY AND ARE TO BE CONSIDERED AS INCORPORATED INTO AND CONSTITUTING A PART OF THE ISSUED POLICY.

THE POLICY WILL BE VOID IF THE APPLICANT HAS CONCEALED OR MISREPRESENTED ANY MATERIAL FACT OR CIRCUMSTANCE CONCERNING THE SUBJECT OF THIS APPLICATION.

THE APPLICANT HEREBY REPRESENTS THAT THE INFORMATION CONTAINED IN THIS APPLICATION, THE DISCLOSURE STATEMENT, AND ALL INFORMATION AND DOCUMENTS OTHERWISE PROVIDED TO THE COMPANY HAS BEEN REVIEWED BY THEM AND IS TRUE AND COMPLETE TO THE BEST OF THEIR KNOWLEDGE AND BELIEF.

Name of authorized representative of Plan Sponsor (Applicant):	Title:
Signature of Authorized Representative:	Today's Date: