

EXCESS RISK SINGLE EMPLOYER APPLICATION (GA)

ReliaStar Life Insurance Company
("ReliaStar Life")

Home Office: Minneapolis, Minnesota 55440

Plan Sponsor hereby applies for the Excess Risk Policy.

PLAN INFORMATION

Name of Plan Sponsor (exact legal name) Effingham County Board of Commissioners
Address (number and street) 601 North Laurel Street
City Springfield State GA Zip 31329

Corporation Partnership Sole Proprietorship Other. Specify: Unit of Government

Nature of Plan Sponsor's Business Government SIC Code 9121

Are subsidiaries, affiliates or other associated entities to be included? Yes No

If "Yes," give Names. _____

Relationship to Plan Sponsor _____

Please provide the number of individuals covered as noted below:

Eligible Individuals	_____	Covered Persons Only	_____	Covered Persons with Dependents	_____
Enrolled Individuals	<u>406</u>	Covered Persons Only	<u>249</u>	Covered Persons with Dependents	<u>157</u>
Individuals Covered Elsewhere	_____	Covered Persons Only	_____	Covered Persons with Dependents	_____

The initial Contract Period is from January 1, 2024 through December 31, 2024

CLAIM ADMINISTRATOR INFORMATION (Claim Administrator for coverages checked below for the Employee Benefit Plan)

Name of Claim Administrator (exact legal name of entity) Meritain Health, CVS Caremark (Rx)

Address (number and street) N/A

City N/A State N/A Zip N/A

Note: The plan Sponsor's self-funded welfare benefit plan is not regulated nor approved under the insurance laws of Georgia.

* Claim Administrator must be approved by ReliaStar Life prior to acceptance of this Application

INDIVIDUAL EXCESS RISK

Individual Excess Risk: Yes No

Benefits To Be Covered: Medical Other (Please specify) Prescription Drugs

Initial Coverage Period:

Incurred and Paid in 12 months Incurred in 12 months and Paid in 15 months
 Incurred in 15 months and Paid in 12 months Incurred in 24 months and Paid in 12 months
 Paid in 12 months
 Other _____

Individual Excess Risk Deductible \$ 125,000 per Individual

Individuals subject to the Individual Adjusted Deductible as identified in the disclosure process

n/a

Claims for Individuals subject to the Individual Adjusted Deductible that exceed the Individual Excess Risk Deductible amount are excluded under any Aggregate Excess Risk Insurance.

Benefit percentage 100%

ACKNOWLEDGEMENT & SIGNATURES

By signing this Application below, the Plan Sponsor Applicant represents that all statements, answers and information made above in this application and in the Disclosure Agreement are complete and true to the best of its knowledge and belief. Plan Sponsor Applicant further acknowledges and agrees (i) that such statements, answers and information in this Application and in the Disclosure Agreement, together with a copy of the Employee Benefit Plan and other information attached to this application or furnished to ReliaStar Life, are submitted by the Plan Sponsor Applicant as an inducement to, and will be relied upon by, ReliaStar Life, in underwriting this risk and determining whether to accept this application and issue the Excess Risk 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 ReliaStar Life, any policy issued by ReliaStar Life may be rescinded and/or any benefits that might otherwise be payable thereunder may be denied; and (iii) the Plan Sponsor Applicant has fully read and understands this completed Application and the Disclosure Agreement.

Plan Sponsor Applicant Effingham County Board of Commissioners

Name of Signer (*Please print*) _____ Date Signed _____

 By _____ Title _____

DISCLOSURE AGREEMENT

ReliaStar Life Insurance Company, Minneapolis, MN
A member of the *Voya*® family of companies
(the "Company")



Policy Effective Date January 01, 2024

Plan Sponsor Name Effingham County Board of Commissioners

INSTRUCTIONS FOR COMPLETION

Please provide the information described in the Disclosure Reports Section below and then have an authorized representative of the Plan Sponsor submit the Disclosure Agreement. Prior to submitting this Disclosure Agreement and Disclosure Reports to the Company, please consult with your current Claim Administrator(s), Utilization Review Firm(s), Case Management, and Pharmacy Benefits Manager(s) (collectively, "Claim Vendors"), and Plan Sponsor's Broker or other insurance advisor. The Disclosure Reports must be provided to the Company no earlier than 90 calendar days prior to the Policy's Effective Date or renewal date, as applicable. Please note the required monthly claim reporting provided on behalf of the Plan Sponsor to Company will suffice for renewal purposes. Should the Company require any additional information, it will notify the Plan Sponsor and/or its designated representative in writing no later than 20 calendar days following receipt of the Disclosure Reports. Any firm quote is void unless accepted by the Plan Sponsor in writing within 30 days from the date quoted by the Company.

DISCLOSURE REPORTS *Plan Sponsor has provided the following reports or data (which include claimant name and primary ICD-10 diagnosis) on the following date(s):* _____

- Any individual with paid claims that has exceeded 50% of the stop loss deductible during the applicable current policy year (minimum 9 months);
- Any individual with denied and/or pended claims that has exceeded \$25,000 during the applicable current policy year (minimum of 9 months);
- Any individual evaluated and/or listed for an organ, stem cell or bone marrow transplant;
- Any individual, including claim amounts for that individual, who is or was in case management or whose condition or diagnosis would be referred to case management during the applicable current policy year (minimum 9 months) by your claims Administrator based upon the ICD-10 codes used by your Claims Administrator for referral to case management;
- Any individual, including claim amounts for that individual, whose condition or diagnosis during the applicable current policy year (minimum 9 months) is represented by any of the ICD-10 codes contained in the attached list.

DISCLOSURE AGREEMENT

The Plan Sponsor represents to the Company, to the best of its knowledge and belief, and after making a diligent and good faith inquiry, that it has fully read and understands this Disclosure Agreement; and as of the date of submitting this Disclosure Agreement there are no known potential catastrophic claims other than those disclosed on the submitted Disclosure Reports.

The Plan Sponsor understands and agrees that the Company will rely on this Disclosure Agreement and the attached Disclosure Reports to:

- (i) underwrite this risk,
- (ii) determine whether or not to issue (or renew) a Policy, and
- (iii) If the Company agrees to issue or renew a Policy, determine the terms, conditions, limitations and rates of or for such Policy.

The Plan Sponsor further understands and agrees that if there are any undisclosed claimants known to the plan sponsor that are material to the risk to be insured by the Company, any Policy issued or renewed by the Company may be rescinded, any benefits that might otherwise be payable thereunder may be denied, and/or the premium rates, deductibles, terms, conditions and limitations of the Policy may be revised by the Company; and, the requirement to submit any required Disclosure Report may not be waived by the Company without a written representation by the Plan Sponsor that there are no reports or data with respect to any individual required to be included on any of the Disclosure Reports above.

To be eligible for a claim of reimbursement under the Policy, the Plan Sponsor or the Claims Administrator must request payment and provide complete and accurate Proof of Loss, in the form and content acceptable to the Company, to support a claim within 180 days after the end of the Coverage Period of the Policy.

ICD-10 CODES FOR DISCLOSURE NOTIFICATION

The following ICD-10 Codes for Disclosure Notification provide conditions or diagnosis which must be disclosed. Please list all Plan Participants who have been diagnosed with or treated for any of the Codes listed under the following categories during the current Benefit Period. Where a range of Codes is shown, any and all conditions or diagnosis within that range must be disclosed.

A00-B99 Infectious Diseases

B17.1-B17.11 Hepatitis C

C00-D49 Neoplasms

C00-C14 Malignancies of oral cavity and pharynx
C15-C26 Malignant neoplasm of digestive organs
C30-C39 Malignant neoplasm of respiratory
C43-C44 Melanoma
C50-C50 Breast Malignancies
C51-C68 Genitourinary Malignancies
C69-C72 Malignancies of Nervous System
C81-C96 Leukemias, Lymphomas and Myelomas

D50-D89 Hematologic Disorders

D57.1 Sickle Cell Anemia
D61.01 Aplastic Anemia
D66 Hemophilia/Hereditary Factor VIII Deficiency
D81.0 Severe Combined Immune Deficiency (SCID)
D82.1 DiGeorge Syndrome
D83.1 Immune Deficiency T Cells (AIDS)
D84.1 Alpha 1-Antitrypsin

E70-E88 Metabolic Disorders

E75.22 Gaucher's Disease
E84.0 Cystic Fibrosis

G00-G99 Disease of the Nervous System

G12.21 Lou Gehrig's disease (ALS)
G61.0 Guillain-Barre Syndrome
G82.50 Quadriplegia
G91.1 Obstructive Hydrocephalus

I00-I99 Disease of Circulatory System

I27.0 Primary Pulmonary Hypertension
I42.0-I42.9 Cardiomyopathy
I46.9 Cardiac Arrest
I60.9 Subarachnoid Hemorrhage

J00-J99 Disease of Respiratory System

J96.00-J96.92 Respiratory Failure

K00-K95 Disease of Digestive System

K70.0-K74.69 Chronic Liver Disease
K72.00-K72.91 Liver Failure

M86 Diseases of Musculoskeletal System and Connective Tissue

M86 Osteomyelitis

N00-N99 Disease of Genitourinary System

N18.1-N18.9 Chronic Renal Failure

O00-O9A Pregnancy, Childbirth & Puerperium

O30.10--O30.109 Triplet Pregnancy
O30.20-O30.209 Quadruplet Pregnancy
O60.00--O60.14 Preterm Labor

P00-P96 Perinatal Conditions

P07.00-P07.36 Preterm Infant
P22.0 Respiratory Distress Syndrome of Newborn

Q00-Q99 Congenital Malformations

Q20-Q28 Congenital Heart Diseases
Q39.0-Q39.4 Tracheoesophageal Fistula
Q89.7 Multiple Anomalies

S00-T88 Injury, Poisoning and Trauma

S06.0-S06.9 Brain Injuries
S12-S14 Spinal Cord Injuries
S88 Amputations
T07 Multiple Trauma Injuries
T20-T32 Burns
T79 Early Complications of Trauma

T86-Z94 Complications Peculiar to Certain Specified Conditions

T86.00-T86.02 Graft vs. Host Disease
T86.00-T86.09 Graft vs. Host Disease
T86.90-T86.92 Complications of Transplants
T86.90-T89.99 Complications of Transplants
Z94 Transplants