

MANAGED CARE EXCESS RISK REINSURANCE AGREEMENT
Agreement No.: 420980

(the “Agreement”)

issued to

County of Ventura as Owner and Operator of the Ventura County Health Care Plan
Oxnard, CA

(the “Plan”)

and

RGA REINSURANCE COMPANY
Chesterfield, Missouri

(the “Reinsurer”)

TABLE OF CONTENTS

| <u>ARTICLE</u> | | <u>PAGE</u> |
|-----------------------|-------------------------------|--------------------|
| | Schedule of Coverage | 3 |
| ARTICLE 1 | Definitions | 4 |
| ARTICLE 2 | Utmost Good Faith | 8 |
| ARTICLE 3 | Licensure | 8 |
| ARTICLE 4 | Covered Member Types | 8 |
| ARTICLE 5 | Liability of the Reinsurer | 8 |
| ARTICLE 6 | Premium | 10 |
| ARTICLE 7 | Loss Notices and Settlements | 11 |
| ARTICLE 8 | Extra Contractual Obligations | 12 |
| ARTICLE 9 | Access to Records | 13 |
| ARTICLE 10 | Confidentiality | 13 |
| ARTICLE 11 | Arbitration | 13 |
| ARTICLE 12 | Renewal and Termination | 15 |
| ARTICLE 13 | Material Change | 16 |
| ARTICLE 14 | Other Coverage | 17 |
| ARTICLE 15 | Insolvency | 18 |
| ARTICLE 16 | Exclusions and Limitations | 18 |
| ARTICLE 17 | Miscellaneous | 19 |
| ATTACHMENT A | Provider Fee Schedule | 23 |
| APPENDIX ER | Experience Refund | 24 |
| APPENDIX AB | Audit Bonus | 25 |
| EXHIBIT A | ROSE® Services | 26 |

SCHEDULE OF COVERAGE

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| PLAN(S): | County of Ventura as Owner and Operator of the Ventura County Health Care Plan |
| AGREEMENT NUMBER: | 420980-002 |
| EFFECTIVE DATE: | July 1, 2024 |
| COVERED MEMBER TYPES: | Commercial HMO |
| AGREEMENT PERIOD: | July 1, 2024 through June 30, 2025 |
| CLAIMS BASIS: | Losses that are: <ul style="list-style-type: none">• Incurred from July 1, 2024 through June 30, 2025;• Paid and reported by January 31, 2026; and• Submitted by February 28, 2026. |
| ELIGIBLE SERVICES: | Inpatient Hospital Services (including Transplant Services) Skilled Nursing Facility Services Outpatient Health Services Physician Services (Transplant Only) Drug Related Services (includes Retail Prescription Drugs) Durable Medical Equipment Medical Transportation Hospice Care Services Home Health Care Services Regenerative or Advanced Therapies Out of Area Emergency Services |
| ALLOWABLE CHARGES: | See Article 5 |
| PLAN DEDUCTIBLE: | \$360,000 per Member per Agreement Period |
| COINSURANCE: | 90% (Plan retains 10%) |
| REINSURANCE LIMITS: | Unlimited per Member per Agreement Period |
| PREMIUM: | \$36.90 per Member per month \$300,000 Minimum Annual Premium Required |
| EXPERIENCE REFUND: | Appendix ER |

ARTICLE 1: DEFINITIONS

The following definitions apply to the terms used in this Agreement. In the event of conflict in the meaning of the terms or the content of provisions between this Agreement and the Member Service Agreements, provider contracts or management service contracts, the definitions and provisions of this Agreement will govern.

1.2 “Agreement Period” means the period of time beginning on the first date and ending at midnight (Pacific Time) on the last date shown in the Agreement Period section of the Schedule of Coverage.

1.3 “Coinsurance” means the percentage of eligible expenses paid by the Reinsurer in excess of the Plan Deductible, as indicated in the Schedule of Coverage.

1.4 “Custodial Care” means services occurring in different settings which follow an episode of acute illness or injury where the patient is considered medically stable and no longer demonstrates measurable signs of improvement. .

1.5 “Eligible Services” means all of the medical services provided to a Member for which the Reinsurer has agreed to provide reinsurance coverage pursuant to the terms of this Agreement, as selected by the Plan and outlined in Article 5 - Liability of the Reinsurer. Only services incurred during the Agreement Period are Eligible Services.

If a Member is inpatient hospital or facility confined on the date membership terminates, and the Plan is liable for services provided to that Member for additional days or until discharged, then those services provided during the duration of that confinement shall also be considered Eligible Services under this Agreement, to the extent they otherwise qualify under Article 5 - Liability of the Reinsurer.

Eligible Services may include some, or all, of the following defined services:

- a. **“Inpatient Hospital Services”** means those acute care, short-term diagnostic and therapeutic services, provided in a licensed acute care hospital, for which there is a room and board charge. Examples of services not included in Inpatient Hospital Services are Physician Services, Custodial Care, Long Term Acute Care Services, Subacute Care Services and Skilled Nursing Facility Services.
- b. **“Inpatient Rehabilitation Services”** are services that are part of a separate and distinct inpatient program that provides skilled rehabilitation care to registered bed patients.
- c. **“Long Term Acute Care Hospital (LTACH) Services”** means comprehensive inpatient services provided in a licensed acute care hospital for patients who require specialized, complex services, and are stable enough to move to an LTACH. These services require daily physician monitoring and intensive nursing care, generally with a length of stay of twenty-five (25) consecutive calendar days or more. Examples include ventilator dependent patients and patients requiring wound care

management, IV therapy, dialysis, and telemetry. For purposes of this Agreement, Long Term Acute Care Services are covered only as Skilled Nursing Facility Services, with the exception of intensive care unit (ICU) days, which will be covered as Inpatient Hospital Services.

- d. **“Outpatient Health Services”** means those diagnostic and therapeutic services and products, generally and customarily provided in an ambulatory care or home setting. Outpatient Health Services shall also include the facility charges for ambulatory surgical procedures, x-rays and diagnostic procedures, radiation therapy, lab and pathology, medical supplies, durable medical equipment and ambulance charges. Examples of services not included in Outpatient Health Services are Inpatient Hospital Services, Physician Services, or Custodial Care.
- e. **“Drug Related Services”** means eligible services for hemodialysis and related services, oral, self-administered or professionally administered chemotherapy agents and related services; self-administered or professionally administered injectables, IV therapy, and blood products; and Specialty Drugs. Retail Prescription Drugs are included in Drug Related Services.
- f. **“Specialty Drugs”** means high cost (cost in excess of \$1,500 per 30 day supply) oral, injectable, infused, or inhaled medications that are either self-administered or professionally administered and are used in either a home or health care setting.
- g. **“Physician Services”** means those services generally and customarily provided by a licensed physician or surgeon for which they generally and customarily make a charge. These services may include supplies (materials such as sterile trays or casting materials provided by the physician or surgeon over and above those customarily included with an office visit) and professional charges for lab or x-ray services.
- h. **“Skilled Nursing Facility Services”** means restorative services received in a licensed skilled facility, either freestanding or part of a hospital, that accepts patients in need of rehabilitation and medical care that is of a lesser intensity than that received in an acute care hospital. The skilled nursing facility shall provide twenty-four-hour skilled nursing services under the supervision of a physician.
- j. **“Transplant Services”** means those inpatient or Outpatient Transplant Services that are provided for solid organ or stem cell (bone marrow or peripheral stem cells) transplantation, including organ or stem cell acquisition, transplant procedure, hospital and ancillary services. Transplant Services do not include Outpatient Health Services or Physician Services unless they are included in a Transplant Global Rate and paid at the Transplant Global Rate. Transplant Services also include any affiliated access fees charged by a transplant network in association with the organ or stem cell transplantation. Transplant Services may also include charges for transportation and lodging associated with the Member receiving Transplant Services at a transplant network facility, provided that they are included in the Member Service Agreement.

- k. **“Outpatient Transplant Services”** means bone marrow or stem cell transplant services beginning on the first day of preparative or mobilization therapy and ending thirty (30) calendar days after the stem cell infusion. Outpatient Transplant Services also includes the stem cell harvesting charges. Outpatient Transplant Services are covered under Transplant Services. Outpatient expenses which do not meet the above criteria will not be eligible under Transplant Services but may be eligible under Outpatient Health Services.
- l. **“Transplant Global Rate”** is a pre-negotiated, inclusive case rate or flat fee (including Diagnosis Related Group (DRG) or per diem arrangements) that generally includes the transplant procedure and inpatient or outpatient hospital charges, and may also include transplant evaluation charges, organ acquisition, and physician charges. The Transplant Global Rate may designate a certain number of inpatient days that the flat fee covers and include a provision for additional inpatient days to be paid at a per diem rate. It may also include an inlier provision which designates that the negotiated payable amount will be the lesser of the case rate or a percent of billed charges.
- m. **“Durable Medical Equipment”** means medical equipment ordered by a health care provider including, but not limited to, orthotics, prosthetics or implants.
- n. **“Medical Transportation”** ground or air ambulance transportation for emergency transport; or for transfers between inpatient facilities for Eligible Services.
- o. **“Retail Prescription Drugs”** mean prescription drugs (a) eligible under the Company’s pharmacy benefit, pharmacy rider, pharmacy card program or other such pharmacy provision of the policy of coverage and (b) dispensed and billed by a pharmacy, mail order pharmacy or pharmacy benefit manager.
- p. **“Regenerative or Advanced Therapies”** are products designed to cure disease, transform disease treatment and restore functionality. These include cell and gene therapies approved by the U.S. Food and Drug Administration and related agencies. It is understood and agreed that the Company must provide all related review guidelines and review of the specific claimant with the claim submission.
- q. **“Hospice Care Services”** means palliative and supportive medical care and other services provided by an interdisciplinary team under the direction of an identifiable hospice administration to meet the physical, psychological, spiritual, and social needs of a terminally ill person and his or her family. These services are provided through a centrally coordinated program that ensures continuity and consistency of home and inpatient care that is provided directly or through an agreement.
- r. **“Home Health Care Services”** means care provided in accordance with a plan of care prescribed by a licensed physician, for example care provided by a registered nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed physical, speech or occupational therapist.

- S. **“Out of Area Emergency Services”** means medical care sought for an emergency health condition outside of a managed care organization’s geographic service area.
- T. **"Subacute Care Services"** means comprehensive inpatient services for patients who do not require acute care services, but continue to require short-term, complex interventions. Examples include ventilator dependent patients, including newborns, and patients requiring medically complex treatment such as wound healing, IV therapy, pain management or AIDS treatment care. Subacute Care Services can be provided in a variety of settings, including skilled nursing facilities, acute hospitals, and long-term acute care facilities. For purposes of this Agreement, Subacute Care Services are covered only as Skilled Nursing Facility Services.

1.6 “Incurred” means the date services are rendered or supplies are provided to the Member.

1.7 “Insolvent” or “Insolvency” means:

- a. The entry by a court of competent jurisdiction of:
 - 1. A final order declaring the Plan insolvent, or
 - 2. A final order appointing a receiver or receivers, or trustee or trustees, or liquidators, of the Plan or of all or any substantial part of its property; or
- b. The entry of an order pertaining to the Plan for relief under Title 11 of the United States Code or any similar order under any applicable law or statute of the United States or any state thereof.

1.8 “Loss” or “Losses” means expenses for Eligible Services Incurred during the Agreement Period by a Member in the course of treatment for an injury or sickness as defined in the Member Services Agreement. Losses must be paid by the Plan prior to being considered for reimbursement under this Agreement. For services where there are no specific fees or service charges, but reimbursement is provided for under an alternative payment arrangement, proof of services rendered provided to Reinsurer will, at Reinsurer's discretion, be allowed in lieu of proof of payment. A Loss shall be deemed incurred on the date on which the Member receives the service or treatment. Date of payment is evidenced by the date of the check issued in payment of such service or treatment and/or date of entry to Plan's general ledger. In no event shall the reinsurance coverage be more than the actual amount for which the Plan is liable Loss(es) shall not include loss adjustment expenses, ex gratia payments, interest, withholds, or capitation payments paid by the Plan.

1.9 “Material Change” means a change that materially alters the nature, quality or quantity of the business or risk of the Plan that is likely to impact the Reinsurer’s financial experience under this Agreement. A Material Change Includes, but is not limited to, the following:

- a. A merger, consolidation or reorganization of the Plan, which results in substantial restructuring of the Plan's corporate or financial structure, or an acquisition of substantially all of its assets;
- b. A change in the operations or financial condition of the Plan that has the potential to compromise, or has in fact compromised, the quality of the business risk of the Plan or its performance;
- c. Changes in the Plan's Member Services Agreements including any changes or modifications in any covered benefits included in the Member Service Agreement which would materially alter the type or amount of benefits provided or the terms or conditions for eligibility or participation (e.g., the elimination of a significant exclusion);
- d. Any changes or modifications to contracted rates in excess of 25% with providers;
- e. Misinformation, misrepresentation or changes in the information provided by the Plan to the Reinsurer, directly or indirectly, upon which assessment of risk was based and that has the potential to compromise, or has in fact compromised, the quality of the business risk of the Plan or its performance;
- f. A continuing failure to provide notices as required by Article VII – Loss Notices and Settlements; or
- g. Changes in the Plan, which may increase or extend the liability or exposure of the Reinsurer in a material way.

1.10 “Member” means an individual who is:

- a. enrolled and eligible to receive benefits and/or services within the terms and provisions of the Member Service Agreement;
- b. included in the Covered Member Types identified on the Schedule of Coverage; and
- c. for whom reinsurance premium is paid according to the terms of this Agreement.

1.11 “Member Service Agreement(s)” means the contractual agreement(s) that describe covered services to a Member of the Plan.

1.12 “Network Hospital(s)” means the hospital(s) listed on Attachment A as may be amended from time to time by mutual agreement of the parties.

1.13 “Plan Deductible” means the amount of Loss(es) retained by the Plan without reimbursement by the Reinsurer, as set forth in the Schedule of Coverage.

1.14 “Premium” means the amount to be remitted to the Reinsurer, as set forth in the Schedule of Coverage.

1.15 “Reinsurance Limits” means the amount of reinsurance coverage in excess of the Plan Deductible provided under this Agreement for Losses Incurred during the Agreement Period with respect to any one Member, as set forth in the Schedule of Coverage.

ARTICLE 2: UTMOST GOOD FAITH

The Plan and the Reinsurer enter into this Agreement with the understanding that the principles of utmost good faith traditional to reinsurance will be adhered to in the formation and performance of this Agreement and will govern the parties’ rights and obligations.

ARTICLE 3: LICENSURE

This Agreement is conditioned upon the Plan having a valid license to operate in the **State of California**, and all other licenses and approvals needed to conduct the business reinsured under this Agreement.

ARTICLE 4: COVERED MEMBER TYPES

The Covered Member Types are set forth in the Schedule of Coverage and are limited to those Member Services Agreements issued in the United States. All Members under each Member Service Agreement must be covered under this Agreement.

ARTICLE 5: LIABILITY OF THE REINSURER

The Reinsurer agrees to indemnify the Plan for Losses for the following Eligible Services:

5.1 Inpatient Hospital Services including Transplant Services, Network Access Fees and Associated Charges are limited for each Member to the lesser of:

- (i) Contracted rates including DRG payments (as approved and on file with Reinsurer and included on Attachment A); or
- (ii) The amount paid by the Plan;

5.1a (1) Transplant Services. Transplant Services will be considered eligible expenses under the Inpatient Hospital Services provision of this agreement.

(2) Network Access Fees. Transplant network access fees shall be eligible for reinsurance reimbursement.

(3) Associated Charges. Transportation and lodging charges associated with the Member receiving transplant services shall be considered as Eligible Services.

5.2 Skilled Nursing Facility Services are limited for each Member to the lesser of:

- (i) Contracted rates (as approved and on file with Reinsurer and included on Attachment A); or
- (ii) The amount paid by the Plan.

5.3 Outpatient Health Services. are limited for each Member to the lesser of:

- (i) Contracted rates (as approved and on file with Reinsurer and included on Attachment A); or
- (ii) The amount paid by the Plan.

5.4 Physician Services for “Transplant Services Only” are limited for each Member to the lesser of:

- (i) Contracted rates (as approved and on file with Reinsurer and included on Attachment A); or
- (ii) The amount paid by the Plan.

5.5 Drug Related Services are limited for each Member to the lesser of:

- (i) Contracted rates (as approved and on file with Reinsurer and included on Attachment A); or
- (ii) The amount paid by the Plan.

5.6 Durable Medical Equipment are limited for each Member to the lesser of:

- (i) Contracted rates (as approved and on file with Reinsurer and included on Attachment A); or
- (ii) The amount paid by the Plan.

5.7 Medical Transportation are limited for each Member to the lesser of:

- (i) Contracted rates (as approved and on file with Reinsurer and included on Attachment A); or
- (ii) The amount paid by the Plan.

5.8 Regenerative or Advanced Therapies are limited for each Member to the lesser of:

- (i) Contracted rates (as approved and on file with Reinsurer and included on Attachment A); or
- (ii) The amount paid by the Plan.

5.9 Hospice Care Services are limited for each Member to the lesser of:

- (i) Contracted rates (as approved and on file with Reinsurer and included on Attachment A); or
- (ii) The amount paid by the Plan.

5.10 Home Health Care Services are limited for each Member to the lesser of:

- (i) Contracted rates (as approved and on file with Reinsurer and included on Attachment A); or
- (ii) The amount paid by the Plan.

5.11 Out of Area Emergency Services are limited for each Member to the lesser of:

- (i) Contracted rates (as approved and on file with Reinsurer and included on Attachment A); or
- (ii) The amount paid by the Plan.

5.12 Reinsurance Limits. The maximum reinsurance amount payable per Member during any Agreement Period will be Unlimited. In no event will the reinsurance coverage be more than the actual amount for which the Plan is liable.

5.13 Deductible. The Reinsurer is not liable for any Loss(es) within the Plan Deductible. The Reinsurer shall indemnify the Plan for the amount(s) by which such Loss(es) exceed the Plan Deductible during the Agreement Period, not to exceed the Reinsurance Limits.

If applicable, any Loss Incurred by the Plan on a covered Member during the last thirty-one (31) calendar days prior to this Agreement Period which did not result in a recovery under a prior reinsurance contract because the Plan Deductible was not satisfied will be applied for that same covered Member for this Agreement Period.

ARTICLE 6: PREMIUM

6.1 Condition Precedent. The payment of Premiums is a condition precedent to the liability of the Reinsurer under this Agreement.

6.2 Premium Due. The Plan shall remit to the Reinsurer the Premium as set forth in the Schedule of Coverage. Premiums for each month during the Agreement Period are due thirty (30) calendar days from the end of that month. If Premiums are not received by the due date this Agreement may be terminated as set forth in Article 12 - Renewal and Termination. Minimum premium adjustments are due sixty (60) calendar days after the end of the Agreement Period.

6.3 Premium Basis. Premiums are based on an estimated number of Members for each Covered Member Type covered by this Agreement for the upcoming month, and an adjustment for the previous months' actual number of Members. Monthly adjustments will not be made more than three (3) months after the month for which the adjustment applies. The Reinsurer shall have the right to adjust the premium for any Material Changes as set forth in Article 13 - Material Changes.

ARTICLE 7: LOSS NOTICES AND SETTLEMENTS

7.1 Loss Payments. All Loss payments made by the Plan within the terms of this Agreement and the terms and conditions of the Member Services Agreement shall be binding upon the Reinsurer. The Reinsurer agrees to pay all amounts for which it becomes liable upon receipt of reasonable evidence of the amount due, or to be due, from the Plan. Losses must be paid by the Plan prior to being considered for reimbursement under this Agreement.

7.2 Pre-Notification of Certain Losses. The Plan shall notify the Reinsurer no later than thirty (30) calendar days whenever the Company's aggregate payments for Losses Incurred by any one Member exceed fifty percent (50%) of the Plan Deductible

7.3 Notification of Losses.

- a. **General Reporting Guidelines.** In no event shall the Reinsurer be liable to the Plan for Losses unless the following conditions are met:
 1. The Plan submits a monthly reinsurance Loss report within thirty (30) calendar days of the end of each month;
 2. The Plan pays and reports Losses to the Reinsurer in writing the earlier of:
(i) the time period stipulated in the Claims Basis section of the Schedule of Coverage; or (ii) seven (7) months] after Termination; and
 3. The Plan submits a completed Request for HMO Reinsurance Reimbursement form in a mutually agreed upon format, including all required back-up supporting data, which is received by the Reinsurer the earlier of: (i) the time period stipulated for submitting Losses in the Claims Basis section of the Schedule of Coverage; or (ii) eight (8) months after termination. Upon the Reinsurer's request, the Plan shall provide any additional information the Reinsurer reasonably deems necessary to properly determine Losses.
- b. **Exceptions.** The only exceptions to this section are previously reported Losses that are: (i) unsettled Losses due to coordination of benefits, as defined in the applicable Member Service Agreement; (ii) contested claims; or (iii) unsettled Losses subject to subrogation or reimbursement. The Plan will have either the earlier of twelve (12) months after the Agreement Period in which the Loss was Incurred or twelve (12) months after termination to submit these Losses to the Reinsurer.

- c. **Claim Denials.** A claim denial by the Plan that is overturned by an Independent Review Organization (IRO) is considered an Eligible Service subject to all other provisions of this Agreement. The denied Loss(es) will not be subject to the loss reporting or claim submission time limits stated in the Claims Basis section of the Schedule of Coverage or in 7.3a(2) or 7.3a(3) above. The claim denial date will be considered to be the “paid” date for purposes of allocating the eligible Loss under this Agreement. After a claim denial is overturned by an IRO, the Plan must provide proof of payment of the resulting Loss to the Reinsurer within ninety (90) calendar days.

7.4 Loss Settlements. With respect to disputed Losses, all Loss settlements made by the Plan within the terms of this Agreement and the Member Service Agreements, and which do not constitute ex gratia payments, shall be binding upon the Reinsurer.

7.5 Refund. If the Reinsurer makes a payment for a Loss and it is later determined that a lesser amount should have been paid, the Reinsurer shall be entitled to a prompt refund of the excess paid. In no event shall the reinsurance coverage be more than the actual amount for which the Plan is liable on any Loss.

7.6 Right of Association. The Plan shall cooperate with the Reinsurer and furnish the Reinsurer with such information as may be required with respect to disputed Loss(es) and settlements. Upon notification of a disputed Loss(es), the Reinsurer shall have the right to participate in the settlement or the defense of any claim, suit, or proceeding involving this reinsurance at its own expense. The Reinsurer shall notify the Plan as soon as practicable of its decision to participate, but not later than fifteen (15) calendar days after receipt of the Plan’s notice.

7.7 False Claims. If the Plan knowingly submits a false claim or Loss or makes any material misrepresentation relating to a claim or Loss to the Reinsurer, this Agreement may be terminated by the Reinsurer from either the date such false claim or Loss was submitted, or the date on which the material misrepresentation was discovered. The Plan shall reimburse the Reinsurer for any amounts paid under such false claim, Loss, or as a result of the material misrepresentation. If the Reinsurer, in its sole discretion, elects to terminate the Agreement, it shall provide written notice to the Plan stating the reason for termination and termination date.

7.8 Failure to Timely Report. A continual failure by the Plan to submit monthly reinsurance Loss reports to the Reinsurer in a timely manner shall constitute a Material Change and shall allow the Reinsurer all remedies set forth in the Material Change Article.

7.9 Failure to Submit Losses. Failure by the Plan to submit a Loss within the time period specified in the Claims Basis section of the Schedule of Coverage will result in the Reinsurer’s nonpayment of such a Loss. The Reinsurer has no obligation to demonstrate prejudice with respect to this limitation.

7.10 ROSE © Services. A description of ROSE Services provided by the Reinsurer is attached hereto as Exhibit A and shall form a part of this Agreement.

ARTICLE 8: EXTRA CONTRACTUAL OBLIGATIONS

In no event shall the Reinsurer be liable for or participate in punitive damages, compensatory damages, or statutory penalties (hereinafter called “Extra Contractual Obligations”) incurred by or awarded against the Plan in connection with Losses reinsured under this Agreement. Extra Contractual Obligations may include, but are not limited to, amounts paid by the Plan for legal expenses, punitive or exemplary damages, compensatory damages, or any other extra contractual damages awarded to any Member arising out of the conduct of the Plan's investigation, trial, or settlement of any claim, or failure to pay or delay in payment of any benefits or rendering of any services under its Member Service Agreements. Extra Contractual Obligations also include any statutory penalties imposed upon the Plan on account of any unfair trade or unfair claim practices, or any fraudulent or criminal acts by any agent, employee, officer or director of the Plan acting individually, collectively, or in collusion with others.

ARTICLE 9: ACCESS TO RECORDS

Upon request, the Plan shall provide the Reinsurer, or its designated representative, at the Plan's premises or any other office where such documents are stored, with detailed information on the insurance that forms the subject matter of this Agreement, including, at the Reinsurer's expense, copies of the whole or part of any documents relating to the risks and their reinsurance. Such information shall include, but not be limited to, underwriting files, claim files, accounting files, internal and external correspondence, correspondence with intermediaries, audit reports, and actuarial studies as relating to the reinsurance risks. Such information, as well as access to Plan personnel familiar with such information, shall be made available during the Plan's normal office hours to the Reinsurer's representative(s) who shall be named in advance. The Reinsurer shall have this right of access as long as it has obligations under this Agreement, and the Plan agrees to cooperate fully with the Reinsurer in providing this access.

ARTICLE 10: CONFIDENTIALITY

All information disclosed to the Reinsurer by the Plan, or to the Plan by the Reinsurer, either in the course of conducting negotiations or as a result of complying with the terms and conditions of this Agreement, shall be considered proprietary and confidential information (“Confidential Information”) by both parties and shall not be disclosed without written consent of the other, except to affiliates, auditors, attorneys and retrocessionaires, and as required by applicable law or judicial process. The parties agree to maintain strict confidentiality under applicable federal and state laws and regulations relating to personally identifiable health information of Members to which the parties gain access pursuant to this Agreement. Confidential Information shall not include any information which at the time of disclosure, or thereafter, is generally available to and known by the public other than by way of a wrongful disclosure by the Reinsurer or the Plan. These

confidentiality and nondisclosure obligations supersede any prior agreement between the parties addressing such obligations regarding the subject matter of this agreement.

ARTICLE 11: ARBITRATION

11.1 Enforceability. Notwithstanding any choice of law provision in this Agreement, the parties intend this Article to be enforceable in accordance with the Federal Arbitration Act (“FAA”), including any amendments which are subsequently adopted. In the event that either party refuses to submit to arbitration as required herein, the other party may request a United States Federal District Court to compel arbitration in accordance with the FAA. Both parties consent to the jurisdiction of such court to enforce this Article.

11.2 Notice of Arbitration. Any dispute or other matter in question between the Plan and the Reinsurer arising out of, or relating to, the formation, interpretation, performance, or breach of this Agreement, whether such dispute arises before or after termination of this Agreement, and whether in contract, tort, or otherwise, shall be settled by arbitration. To initiate arbitration, either the Plan or the Reinsurer shall notify the other party in writing of its desire to arbitrate. The notice must identify the claimant, the contract at issue, and the nature of the claims and issues. Notice must be sent certified mail with return receipt, or another service which produces a delivery confirmation receipt. The arbitration will be deemed to have been commenced on the date the notice of arbitration is received.

11.3 Arbitrators. There will be a panel of three arbitrators each with no less than ten years of insurance or reinsurance industry experience who are current or former officers of life or health insurance or reinsurance companies other than the parties to this Agreement, their affiliates or subsidiaries. The arbitrators cannot be under the control of any party nor have any financial interest in the outcome of the dispute. However, ex parte communications with party appointed arbitrators shall be permitted until the arbitration hearing commences. Within thirty (30) calendar days following the commencement of the arbitration proceedings, each party will provide the other with the identification of their appointed arbitrator and provide a copy of the arbitrator’s curriculum vitae. If either party refuses or neglects to appoint an arbitrator within thirty (30) calendar days, the other party may appoint the second arbitrator to act as the appointed arbitrator for the defaulting party by providing notice and a copy of the arbitrator’s curriculum vitae. Each party's appointed arbitrator shall propose a candidate (or a slate of up to five candidates) to serve as the third arbitrator (the "umpire"), which shall be subject to the other party's agreement. In the event the two party-appointed arbitrators fail to reach an agreement on an umpire within sixty (60) calendar days of their appointment, then either party may petition ARIAS-U.S. to appoint the umpire and each party shall cooperate and take whatever action is required to give effect to the ARIAS-U.S. umpire appointment procedures. In the event any arbitrator fails, refuses, or becomes unable to act as such before an award has been rendered, a successor shall be selected in the same manner as the original arbitrator.

11.4 Submission of Briefs. The claimant and respondent shall each submit initial briefs to the panel outlining the issues in dispute and the reasons for their respective positions within thirty (30) calendar days of the notice of the appointment of the umpire.

11.5 Scope of Power. The panel shall consider this Agreement an honorable engagement rather than merely a legal obligation and make its decision with consideration given to the custom and usage of the insurance and reinsurance industry. The panel shall have the power to determine all procedural rules of the arbitration, including, but not limited to, inspection of documents, examination of witnesses, and any other matter related to the conduct of the arbitration. The panel shall have the authority to issue subpoenas (including subpoenas to third party witnesses) and other orders to enforce its decisions. The panel shall recognize the attorney-client privilege and the attorney work product doctrine. Neither a party nor an arbitrator may disclose the existence, content, or result of any arbitration, except to the extent such disclosure may be required for review and enforcement by a court of competent jurisdiction, to support reinsurance or retrocessional recoveries, or as otherwise agreed by the parties. The location of all proceedings shall be in the County of Ventura.

11.6 Panel Decision Final and Binding. The panel may issue orders for interim relief upon showing of good cause, including pre-award security. Absent good cause for an extension, as determined by the panel, the panel shall render the final award within nine (9) months of the appointment of the umpire and within thirty (30) calendar days after the date of the closing of the hearing, unless the parties agree otherwise. The panel is authorized to award any remedy or sanction allowed by applicable law, including, but not limited to, monetary damages, equitable relief, pre or post award interest, costs of arbitration, attorney's fees, and other final or interim relief, provided that the panel shall not be empowered to award damages in excess of compensatory damages. The decision of the panel shall be made by majority rule and be final and binding upon both parties. Either party to the arbitration may petition any court having jurisdiction over the parties to reduce the decision to judgment.

11.7 Expenses. Each party shall bear its own costs in connection with any such arbitration, including, without limitation, (a) all legal, accounting, witness or other professional fees and expenses, (b) the fees and expenses of its own arbitrator, and (c) all other costs and expenses each party incurs to prepare for such arbitration. Each party shall pay one-half of the fees and expenses of the umpire and one-half of any other expenses directly related to the arbitration proceeding that the parties jointly agree to share. The parties acknowledge that the foregoing obligations are subject to, and may be superseded by, an award by the panel with respect to such costs and expenses.

ARTICLE 12: RENEWAL AND TERMINATION

12.1 Renewal Process. This Agreement will automatically terminate at the end of the Agreement Period shown in the Schedule of Coverage.

If the Plan desires to renew coverage, it shall submit a completed renewal information form provided by the Reinsurer at least sixty (60) calendar days prior to the end of the Agreement Period. The parties will negotiate a new agreement, but until a new agreement is reached there is no renewal, and coverage under this Agreement will be considered terminated as of the end of the Agreement Period. If the Plan submits Premiums after expiration of the Agreement Period, the

Reinsurer may hold or return such Premiums, but such payment shall have no force or effect with respect to renewing this Agreement or creating a new agreement between the parties.

12.2 Failure to Pay Premium. In the event that Premiums are not paid by their due date, this Agreement may be terminated at the Reinsurer's discretion. If the Reinsurer elects to terminate this Agreement, it shall send notice to the Plan stating the reason for termination and termination date.

Within ninety (90) calendar days of the termination date, this Agreement may be reinstated at the discretion of the Reinsurer upon payment of all Premiums in arrears including any interest accrued thereon at the Reinsurer's standard rates for these purposes. Upon the Reinsurer's acceptance of such payment the termination shall be considered rescinded and this Agreement, along with all its terms and conditions, will be reinstated with full force and effect without any gap in reinsurance coverage.

12.3 Insolvency. Should the Plan become Insolvent, this Agreement shall automatically terminate as of the date of Insolvency.

12.4 Effect of Termination. Except as otherwise specifically provided in this Agreement, termination shall have no effect on the rights or obligations incurred by the parties prior to termination. Nothing in this section shall be construed to extend Reinsurer's liability for reimbursements for any Loss arising, Incurred or paid by the Plan that was not properly paid, reported and submitted within the required time periods otherwise specified in this Agreement.

ARTICLE 13: MATERIAL CHANGE

13.1 Notice of Material Change. The Plan must provide written notice to the Reinsurer of any Material Change. Whenever possible such notice must be made in advance or as soon as reasonably possible after the change, but in no event more than ninety (90) calendar days following a Material Change.

13.2 Effect of Material Change. Upon receipt of a Material Change notice, the Reinsurer may, at its discretion:

- a. Accept the Material Change without revising the Premium rates and/or coverage terms;
- b. Accept the Material Change and revise the Premium rates and/or coverage terms, but if the Plan rejects the revision within thirty (30) calendar days after notice of the revised rates and/or terms, the Agreement shall terminate effective as of the date of the Material Change;
- c. Not accept the Material Change, but continue to provide coverage and adjudicate claims as if the Material Change had not occurred;
- d. Terminate this Agreement effective as of the date of the Material Change.

If this Agreement is terminated in accordance with this provision, then the coverage and premium shall be prorated according to the number of days in the reduced coverage period. In addition, if any Losses were paid by the Reinsurer after the coverage effective date of termination, meaning after the date of the Material Change, such Loss payment outside of the coverage period shall be refunded to the Reinsurer.

Changes in the Agreement as a result of a Material Change will be effective as of the date of the Material Change. Until the Reinsurer accepts any Material Change in the Member Services Agreement which would alter the type or amount of benefits provided or the terms or conditions for eligibility or participation, Losses will continue to be based upon the Member Services Agreement as if unchanged.

13.3 Failure to Give Notice. If the Plan fails to give the Reinsurer timely notice of a Material Change, or fails to give notice at all, the Reinsurer may, at its discretion:

- a. Choose an option described in section 13.2 above; or
- b. Rescind this Agreement as of the coverage period first affected by the Material Change. In which event the Reinsurer will refund all premium paid and the Plan will return all loss payments for the applicable period.

13.4 Legal and Equitable Rights. Nothing in this Article is intended or shall be interpreted to limit any rights the Reinsurer may have or be entitled to under law or the principles of equity, nor shall the Reinsurer's exercise of any right under this Article constitute or be deemed a waiver of other such legal or equitable rights.

ARTICLE 14: OTHER COVERAGE

14.1 Subrogation or Reimbursement. The Reinsurer shall be credited with reimbursement obtained or recovery made by the Plan on account of claims and settlements involving reinsurance less the actual cost of obtaining such reimbursement or making such recovery, excluding salaries of officials and employees of the Plan and sums paid to attorneys as retainer. Such credit will be applied to any amounts either paid by the Reinsurer, or that would be payable by the Reinsurer, under this Agreement. To the extent that the Reinsurer has paid Loss amounts related to the reimbursed or recovered amounts, such credit will be repaid by the Plan to the Reinsurer within ninety (90) calendar days. The Plan hereby agrees to take reasonable action to enforce its rights to reimbursement or subrogation relating to any Loss hereunder.

14.2 Secondary Coverage. If any risk ceded by the Plan is covered by multiple reinsurance coverage, the reinsurance coverage provided by this Agreement shall be considered secondary to any inuring insurance or reinsurance other than the reinsurance provided hereunder, including without limitation, any inuring coverage provided through the United States federal government. Any payments received by the Plan as a result of such other reinsurance coverage will offset the Reinsurer's obligation to the Plan under this Agreement.

14.3 Patient Protection and Affordable Care ACT (PPACA). In consideration of the premium charged it is understood that any financial “reinsurance” recoveries that the Plan is entitled to receive under any federal or state transitional reinsurance program(s) under the Patient Protection and Affordable Care Act (PPACA) shall have no impact on the calculation of any recoveries owed by the Reinsurer to the Plan under this Agreement.

ARTICLE 15: INSOLVENCY

The Plan shall notify the Reinsurer immediately of the pendency of any action which may lead to Insolvency or any intention the Plan may have of ceasing operations. Notice of the Plan’s Insolvency or date of cessation of operations must be communicated to the Reinsurer by the Plan at the earliest possible time.

The Reinsurer shall have no obligation with respect to the administration of underlying Plan benefits or for making any direct payments to any party other than the Plan or its liquidator, receiver, rehabilitator, trustee, administrator or other statutory successor (collectively referred to as the “Successor”). The Reinsurer will make payments directly to the Plan or its Successor, with reasonable provisions for verification, without diminution because of the Insolvency of the Plan.

The Plan or its Successor will cooperate with the Reinsurer in providing full access to the Plan records and personnel, at the Plan’s expense, to enable the Reinsurer to reasonably determine its obligations.

The Plan or its Successor shall give written notice to the Reinsurer of the pendency of any claim(s) against the Plan within a reasonable time after such claim(s) is presented to the Plan or its Successor or when such claim(s) is filed in the Insolvency proceeding. During the pendency of such claim(s), the Reinsurer may investigate and interpose, at its own expense, in the proceeding where such claim(s) is to be adjudicated, any defense or defenses which it may deem available to the Plan or its Successor. As soon as practicable after the Plan becomes Insolvent, the Plan or its Successor shall take any and all steps necessary to obtain any court approval required to permit expenses incurred by the Reinsurer to be chargeable against the Insolvent Plan as part of the expenses of liquidation or rehabilitation. If no such court approval is required, such expenses shall automatically become chargeable as expenses of liquidation or rehabilitation entitled to such priority as may attach as a matter of applicable law. Nothing contained herein requires the Reinsurer to take such actions, and the Reinsurer’s obligations remain limited to the terms of this Agreement.

The Reinsurer and the Plan or its Successor shall have the right to offset to the maximum extent permitted by applicable law.

ARTICLE 16: EXCLUSIONS AND LIMITATIONS

16.1 Exclusions. The Reinsurer shall not be liable to the Plan for any of the following:

- a. Professional liability or liability for any act or omission, tortious or otherwise, in connection with any services rendered to any person or persons by the Plan or any group entity or person employed by or under contract with a provider agreement under the Plan;
- b. Liability assumed by the Plan in excess of the Member Services Agreement, including liability under any contract other than the Member Service Agreement;
- c. Expenses or Losses paid by the Plan as settlement, where the Plan has released any persons or entity from its legal liability;
- d. Any liability, Loss or expense caused or contributed to by war (declared or undeclared), hostilities, invasion, civil war.
- e. Liability as a result of sickness or accidental injury not covered by the Member Service Agreement, unless notice has been provided in accordance with this Agreement and the Reinsurer has specifically agreed to provide coverage;
- f. Damages, actions or claims made against the Reinsurer and caused by the Plan's acts or omissions or failure to use diligence; and
- g. Expenses and losses due to any noncompliance or violation of any law by the Plan.
- h. Long Term Acute Care, Rehabilitation Services, Physician Services except for Transplant Services and Custodial Care.
- i. Capitated services that are no longer the risk of the Plan.

16.2 Limitations. The Plan is solely responsible for arranging for the provision of all services to its Members, for compensation of all liability to its providers and to its Members, and for payment of all expenses to its Members. The Reinsurer has no responsibility for payment of salaries or expenses of the Plan's employees or representatives. The Reinsurer has no responsibility to provide any direct services or pay expenses to any Member. This Agreement is solely between the Reinsurer and the Plan.

ARTICLE 17: MISCELLANEOUS

17.1 Offset. Each party shall have the right to offset any undisputed balances or amounts due from one party to the other under the terms of this Agreement. However, in the event of Insolvency of any party hereto, offset shall only be allowed in accordance with applicable law.

17.2 Intermediary. Beecher Carlson Insurance Services, LLC is hereby recognized as the intermediary negotiating this Agreement for all business hereunder. All communications (including but not limited to notices, statements, premiums, claims), relating to this Agreement shall be transmitted to Plan or Reinsurer through the Intermediary. Payments by the Plan to the Intermediary shall be deemed to constitute payment to the Reinsurer and payments by Reinsurer to the Intermediary shall be deemed to constitute payment to Plan only to the extent that such payments are actually received by the Plan.

17.3 Governing Law. This Agreement shall be governed by the laws of the State of California, without giving effect to principles or conflicts of laws.

17.4 Waiver. The failure of either party to insist on strict compliance with this Agreement, or to exercise any right or remedy available under this Agreement, shall not constitute a waiver of any rights or remedies contained in the Agreement, prevent either party from demanding full and complete compliance, or prevent the parties from exercising such a right or remedy in the future.

17.5 Assignment. This Agreement shall be binding upon and inure to the benefit of the Plan and the Reinsurer and their respective successors and heirs, provided that this Agreement (or any part of it) may not be assigned by either party without the prior written consent of the other, which shall not be unreasonably withheld.

17.6 Taxes and Expenses. Losses with respect to taxes and other related expenses shall not include any expenses incurred by the Plan in connection with its Member Services Agreements, including, but not limited to, dividends, commissions, or taxes.

17.7 Currency. Whenever the word “Dollars” or the “\$” sign appears in this Agreement they shall mean United States Dollars, except where the Member Service Agreements are issued in Canada they shall mean Canadian Dollars. All payments made by either party shall be made in United States Dollars, except that payments made on Member Service Agreements issued in Canada shall be made in Canadian Dollars.

17.8 Errors and Omissions. If either party fails to perform an obligation under this Agreement as a result of an error or omission, any such error or omission shall be corrected, to the extent possible, so that the parties are restored to the positions they would have occupied had no such error or omission occurred. If this is not possible, the parties will endeavor in good faith to promptly resolve the situation in a manner that is fair and equitable and most closely approximates the intent of the parties as evidenced by this Agreement. The parties mutually agree that through a prudent review of their respective records they will identify and correct all other errors and omissions of the same or similar type in a reasonable manner at the earliest possible date. The preceding provisions, however, do not apply to any Loss or claim reporting obligations of the Plan under this Agreement.

17.9 Rules of Construction. The captions and headings in this Agreement are inserted for convenient reference only and are not intended to define, limit, modify or amplify the construction, interpretation or meaning of the terms of, or the scope or intent of, this Agreement. The parties acknowledge and agree that no provision of this Agreement shall be construed against, or interpreted to the disadvantage of, a party by reason of such party having drafted or structured such provision.

17.10 Third Party Beneficiaries. This is a contract between the Plan and the Reinsurer only, and nothing herein shall in any manner create any obligations or establish any rights against either the Plan or the Reinsurer in favor of any third parties or persons not party to this Agreement.

17.11 Notices. All notices and communications, excluding Loss notices, shall be in writing and become effective when received. Any written notice shall be by certified or registered mail, return receipt requested; an overnight delivery service providing for delivery receipt; or delivered by hand.

17.12 Compliance. The Plan and the Reinsurer each represent that to the best of its knowledge and belief it is and shall use its best efforts to continue to be, in substantial compliance in all material respects with all laws, regulations, and judicial and administrative orders applicable to the business reinsured under this Agreement (collectively, the "Law"). This includes the maintenance of an effective anti-money laundering policy to the extent the Plan is required to have such a policy in place. Neither the Plan nor the Reinsurer shall be required to take any action under this Agreement that would result in it being in violation of the Law, which for purposes of companies subject to U.S. regulation, including the Reinsurer, shall include requirements enforced by the U.S. Treasury Department Office of Foreign Asset Control. The Plan and the Reinsurer acknowledge and agree that a claim under this Agreement is not payable if payment would cause the Reinsurer to be in violation of the Law. Should either party discover a reinsurance payment has been made in violation of the Law, it shall notify the other party and the parties shall cooperate in order to take all necessary corrective actions. The Plan will return the reinsurance payment to the Reinsurer to the extent, and at such time, as permitted by Law.

17.13 The Foreign Account Tax Compliance Act. Both the Reinsurer and the Plan agree to provide all information necessary to comply with the Foreign Account Tax Compliance Act (FATCA) consistent with Sections 1471 – 1474 of the US Internal Revenue Code and any Treasury Regulations, or other guidance issued pursuant thereto, including, without limitation, Forms W-9, Forms W-8BEN-E, any information necessary for the Plan to enter into an agreement described in Section 1471(b) of the US Internal Revenue Code and to comply with the terms of that agreement or to comply with the terms of any inter-governmental agreements between the US and any other jurisdictions relating to FATCA. This information shall be provided upon execution of this Agreement, promptly upon reasonable demand by either party to this agreement and promptly upon learning that any such information previously provided has become obsolete or incorrect. The parties to this agreement acknowledge that if it fails to supply such information on a timely basis, it may be subject to a 30% US withholding tax imposed on payments of US source income.

17.14 Severability. If any provision of this Agreement, or its application to any party or circumstance, shall be held by a court or other authority to be invalid or unenforceable, the parties agree that such judgment shall in no way affect the validity and enforceability of other provisions of this Agreement that reasonably can be given effect apart from that which is invalidated.


17.15 Entire Contract. This Agreement, inclusive of all attachments, appendices and exhibits, contains the entire contract between the Plan and the Reinsurer. No representations, promises, understandings or agreements, oral or otherwise, between the parties not contained in this Agreement or attached to it shall be of any force or effect. All changes to this Agreement must be by written amendment and signed by officers of the Plan and the Reinsurer.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed, as of the dates undermentioned.

**COUNTY OF VENTURA AS OWNER
AND OPERATOR OF VENTURA
COUNTY HEALTH CARE PLAN**

RGA REINSURANCE COMPANY


Name: Cliff Chroust

Signature: 

Title: County Chief Procurement Officer

Date: 6-18-2024

Name: Brent Hoehne

Signature: 

Title: Authorized Representative

Date: 6/21/2024

Name: _____

Signature: _____

Title: _____

Date: _____

Name: Kathy Childs

Signature: 

Title: Authorized Representative

Date: 6/20/2024

ATTACHMENT A

Provider Fee Schedule

As on file with Plan; to be provided to Reinsurer upon request.

APPENDIX ER: EXPERIENCE REFUND

The following provision is hereby made an additional part of the Agreement between the Reinsurer and the Plan.

- 1. Requirements.** An Experience Refund shall be provided for this Agreement Period if:
 - a. all Premiums and/or payments due under the Agreement are paid in full to the Reinsurer;
 - b. there have been no Material Changes to this Agreement;
 - c. there is no early termination of this Agreement;
 - d. the premium for this Agreement Period is \$500,000 or greater; and
 - e. the Plan has entered into an agreement with the Reinsurer for a consecutive agreement period, with that agreement period's premium being at least fifty percent (50%) of the average annual premium of this Agreement Period.
- 2. Timing.** The Experience Refund shall be calculated by the Reinsurer ninety (90) calendar days following the expiration of the claims submission period stated in the Claims Basis section of the Schedule of Coverage. The Reinsurer will send documentation of this calculation to the Plan for certification. Upon receipt of the Plan's written certification of the calculation, the Reinsurer will issue the Experience Refund.
- 3. Calculation.** The Experience Refund shall be calculated as follows:
 - a. **Premium Credit.** The Reinsurer shall calculate a credit in the amount of sixty percent (60%) of the Premium received for this Agreement Period.
 - b. **Loss Debit.** The Reinsurer shall calculate the final amount of Losses that have been or shall be reimbursed to the Plan for the Agreement Period.
 - c. **Net Balance.** Premium Credit minus the Loss Debit is the Net Balance.
 - d. **Experience Refund.** The Experience Refund shall be thirty percent (30%) of the Net Balance, provided that the Net Balance is greater than zero (0).
- 4. Deficit Balance.** If the calculation above results in a negative amount, such amount shall be carried forward as a deficit balance and applied against future calculations of the Experience Refund. A deficit balance will be carried forward for a maximum of two (2) agreement periods.

Except as stated herein, all terms and conditions of the Agreement remain unchanged.

APPENDIX AB: AUDIT BONUS

The following provision is hereby made an additional part of the Agreement between the Reinsurer and the Plan.

- 1. Requirements.** An Audit Bonus shall be provided for this Agreement Period if:
 - f. all Premiums and/or payments due under the Agreement are paid in full to the Reinsurer;
 - g. there have been no Material Changes to this Agreement;
 - h. there is no early termination of this Agreement;
 - i. the premium for this Agreement Period is \$300,000 or greater;
 - j. the Plan has entered into an agreement with the Reinsurer for a consecutive agreement period, with that agreement period's premium being at least fifty percent (50%) of the average annual premium of this Agreement Period; and
 - k. the Plan utilizes one of the following external audit providers for inpatient confinements of a reinsurance claimant that both exceeds the deductible and is eligible for reimbursement under this Agreement:
 1. Optum Focused Claim Review
 2. United Claim Solutions, LLC d/b/a Valenz Claim
- 4. Timing.** The Audit Bonus shall be calculated by the Reinsurer ninety (90) calendar days following the expiration of the claims submission period stated in the Claims Basis section of the Schedule of Coverage and recalculated within ninety (90) calendars days of any further reimbursements or adjustments to eligible claimants under this Agreement. The Reinsurer will send documentation of this calculation to the Plan for certification. Upon receipt of the Plan's written certification of the calculation, the Reinsurer will issue the Audit Bonus.
- 5. Calculation.** The Audit Bonus will be 20% of the accumulated savings for inpatient confinements that result in savings to the Reinsurer. The calculation will be based on reports provided by the approved external audit vendor and the reimbursement requests as submitted by the Plan. The Audit Bonus will be subject to a maximum total payment of \$150,000 for all eligible claimants during this Agreement Period.

Except as stated herein, all terms and conditions of the Agreement remain unchanged and apply.

EXHIBIT A
ACCESS TO ROSE® SERVICES
PROVIDED BY
RG A REINSURANCE COMPANY

1. Services. This Exhibit addresses the provision of the following services (collectively, the “ROSE Services”).

| <i>ROSE Service</i> | <i>Description</i> | <i>Fee</i> |
|--|--|--|
| Complex Claim Case Management Services – Internal and Retained Resources | <ul style="list-style-type: none"> Access to individual and third party consultants (the “ROSE Consultants”) who will provide recommendations on current case management procedures and cases pursuant to a separate agreement; Access to resources for research on conditions, treatments, and other healthcare topics as determined to be appropriate by the Reinsurer | No fee for access or case management services provided by the Reinsurer. |
| Complex Claim Case Management Services – External Resources | <ul style="list-style-type: none"> Referrals to specialized case managers and physicians and other professional consultants in specialized areas as determined to be appropriate by the Reinsurer. | <p>Perinatal and neonatal physician consultation services and one other sub-specialty physician consultation at no charge</p> <p>Fees charged by third-party experts providing sub-specialty physician consultation services are available on a fee-for-service basis as set forth in the applicable Access Agreement.</p> |
| Educational Resources | <ul style="list-style-type: none"> Invitation to attend ROSE Conferences, access to ROSE Guides, ROSE Reports, and continuing education webinars. | No fee for educational services provided by the Reinsurer. |
| Access to Specialty Services | <ul style="list-style-type: none"> Access and referral to transplant and specialty networks, provider network organizations, member case management, and pharmacy. | [Fee determined by vendor] |

2. Communications. All communications used by the Plan to describe the ROSE Services will be only those materials produced and approved for use by the Reinsurer. The Plan will not use the Reinsurer’s name or trademarks in any communications unless approved in writing by the Reinsurer. The ROSE name is owned by

the Reinsurer and the Reinsurer has and retains all rights to such name. All ROSE related materials prepared by the Reinsurer has and retains all rights to the same.

3. Non-Fiduciary; Responsibility; Disclaimer.

- a. The Reinsurer is not a fiduciary (ERISA or otherwise) of the Plan or for the Plan and Policy and has no discretionary authority in connection with a Policy or the Plan.
- b. The Reinsurer is not providing medical advice, treatment, or care to Members. The Plan remains responsible for the delivery of health services to Members enrolled under its Member Service Agreement(s). All medical treatment decisions will be made by treating providers and Members. Therefore, the Plan acknowledges that the ROSE Services are consultative in nature and the Reinsurer does not make any benefit decisions for the Plan.
- c. Reinsurer makes no representations or warranties regarding the ROSE Services or costs savings as a result of ROSE Services or recommendations or that it will continue to provide ROSE Services.
- d. The Reinsurer reserves the right to change the programs and services offered, from time to time. The Reinsurer is not providing legal, tax, or other similar advice.
- e. The performance of the ROSE Services shall not affect the contractual provisions or the rights and obligations of the Reinsurer and the Plan generally under the Reinsurance Agreement.

4. Indemnity. In recognition of the fact that the Reinsurer is only providing information and the Plan remains responsible for the delivery of health services to Members, the Plan shall hold harmless and indemnify the Reinsurer and the ROSE Consultants from any claims, losses, damages, liabilities, costs, expenses or obligations (including attorneys' fees) arising out of resulting from (a) the negligence or willful acts of the Plan in the non-performance of its obligations in connection with the ROSE Services or any other aspect of this Exhibit; (b) the ROSE Services; and (c) any claim or cause of action brought by the Plan, any Member, or other entity arising from or related to the ROSE Services. The ROSE Consultants shall be considered third party beneficiaries of this paragraph.

5. Termination.

- a. Following termination or expiration of the Reinsurance Agreement, this Exhibit shall continue in force only with respect to claims or expenses incurred during the term of the Reinsurance Agreement for which the Reinsurer has agreed to indemnify the Plan. For avoidance of doubt, the Reinsurer shall have no responsibility hereunder with respect to ROSE® Services provided in connection with claims or expenses incurred following the expiration or termination of the Reinsurance Agreement.
- b. The Plan shall be obligated to pay any applicable fees for the ROSE Services provided through the effective date of any termination of such ROSE Services.
- c. All documentation generated by the Reinsurer in connection with the provision of ROSE Services herein shall be and remain the property of Reinsurer.
- d. Each party will take reasonable steps necessary to assure an orderly transition of the types of ROSE Services provided under this Agreement.

6. Confidentiality. The Plan will maintain the confidentiality of all Reinsurer proprietary and confidential information disclosed to the Plan. The parties will treat this Exhibit as confidential.