ACE American
Insurance Company
(A Stock Company)
Philadelphia, PA 19106

Qualified Clinical Trials Endorsement

POLICY ENDORSEMENT

**TO BE ATTACHED TO AND MADE A PART OF POLICY NO. N10843534
ISSUED TO HOUSING AUTHORITY OF THE CITY OF EL PASO**

BY ACE AMERICAN INSURANCE COMPANY

Effective Date: **July 01, 2015**

This Amendment is made a part of the Policy to which it is attached as of the Effective Date shown above. It applies only to Plan Benefits Incurred and Paid on or after that date. If no Effective Date is shown above, this Amendment takes effect as of the Policy Effective Date. This Amendment is subject to all of the terms, limitations and exclusions of the Policy except as they are changed by it.

Any changes in premium apply as of the first premium due date on or after the effective date of this Amendment.

The Policy has been changed as follows:

Qualified Clinical Trials Amendment

The Company and the Policyholder agree that the **COVERAGE PROVISIONS** of this Excess Loss Insurance Policy is amended as follows:

The Policy will reimburse eligible Plan Benefits, in excess of the Specific Deductible and/or in excess of the Aggregate Deductible, for Routine Patient Care Services furnished in connection with participation in Qualified Clinical Trials as defined by this Amendment.

Additional Provisions

We may require a copy of the Qualified Clinical Trial's study protocol before determining if any benefits are payable under this Amendment.

Benefits paid under this Amendment will be included in the Specific and Aggregate Limits of Liability.

Benefits paid under this Amendment shall not create any legal presumption that We have recommended, directed, endorsed or required any Covered Person's participation in the Qualified Clinical Trial.

Benefits paid under this Amendment shall be subject to all terms and conditions of the applicable Plan Document.

The Company and the Policyholder agree that **DEFINITIONS** of this Excess Loss Insurance Policy is amended as follows:

QUALIFIED CLINICAL TRIALS means clinical trials that meet all of the following conditions:

1. The clinical trial is intended to treat cancer and other life-threatening diseases or conditions in a patient who has been so diagnosed, and
2. The clinical trial has been peer reviewed and is approved by at least one of the following:
   A. One of the United States National Institutes of Health,
   B. A cooperative group or center of the National Institutes of Health,
   C. A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants,
   D. The United States Food and Drug Administration pursuant to an investigational new drug exemption,
   E. The United States Departments of Defense or Veterans Affairs,
   F. Or, qualified Institutional Review Board and,
3. The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that expertise, and
4. The patient meets the patient selection criteria enunciated in the study protocol of participation in the clinical trial, and
5. The patient has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards and,
6. The available clinical or pre-clinical data provide a reasonable expectation that the patient's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial, and
7. The clinical trial does not unjustifiably duplicate existing studies, and
8. The clinical trial must have a therapeutic intent and must, to some extent, assess the effect of the intervention on the patient.

ROUTINE PATIENT CARE SERVICES means health care items or services that are furnished to an individual enrolled in a Qualified Clinical Trial, which is consistent with the usual and customary standard of care for someone with the patient's diagnosis, is consistent with the study protocol for the clinical trial, and would be covered if the patient did not participate in the Qualified Clinical Trial.

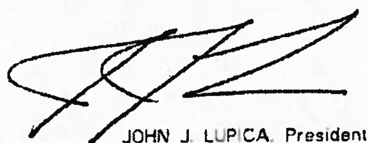
Routine Patient Care Services must be determined to be eligible under the applicable Plan Document.

Routine Patient Care Services do not include any of the following:

1. The investigational drug, device or service, or
2. Non-health care services that a patient may be required to receive as a result of being enrolled in the Qualified Clinical Trial, or
3. Costs associated with managing the research associated with the Qualified Clinical Trial, or
4. Costs that would not be covered for non-investigational treatments, or
5. Any item, service or cost that is reimbursed or otherwise furnished by the sponsor of the qualified Clinical Trial, or
6. The costs of services, which are not provided as part of the Qualified Clinical Trial's stated protocol or other similarly, intended guidelines.

This Amendment ends at the same time as the Policy to which it is attached.

Signed for ACE AMERICAN INSURANCE COMPANY at Philadelphia, Pennsylvania:



JOHN J. LUPICA, President

REBECCA L. COLLINS, Secretary

PREMIUMS:

SPECIFIC: Single: **$24.88** monthly Family: **$73.57** monthly

AGGREGATE: **$5.90** Per Covered Unit Per Month

PLAN BENEFITS INCLUDED

SPECIFIC:
- ☒ Medical
- ☐ Dental
- ☐ Vision
- ☒ Prescription Drugs

AGGREGATE:
- ☒ Medical
- ☐ Dental
- ☐ Vision
- ☒ Prescription Drugs

ENDORSEMENTS INCLUDED:
- ☐ Monthly Aggregate Protection
- ☐ Extended Coverage - Aggregate Excess Loss
- ☐ Extended Coverage - Specific Excess Loss
- ☐ Specific Excess Loss – Simultaneous Reimbursement
- ☒ Specific Advanced Funding Option
- ☐ Limitations on Coverage Endorsement
- ☐ Aggregate Terminal Liability
- ☐ Specific Terminal Liability
- ☐ Specific Retro Arrangement
- ☒ Qualified Clinical Trials Amendment

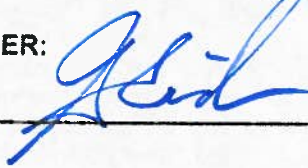
OTHER:

Retirees Covered: Yes ☐ No ☒

Claims incurred prior to July 1, 2015 for Isabel Andrea Duarte (d.o.b. July 13, 1988) will be excluded from the Specific and Aggregate Policy.

POLICY ACCEPTANCE

ACCEPTED BY THE POLICYHOLDER:

Authorized Signature: 

Printed Name: ______________________

Title: ______________________

Date: 10/6/15

DEFINITIONS

ACTIVELY-AT-WORK means:

(1) with respect to a Policyholder's employee or member - the employee/member is working the required number of hours to be eligible for coverage under the Plan and capable of performing his/her normal job duties. Persons absent from work due to regularly scheduled vacation or maternity leave will be considered Actively-at-Work.

(2) with respect to a dependent - being able to perform all the normal activities of a person in good health of the same age and sex and not being confined in a provider facility because of injury or sickness.

AGGREGATING SPECIFIC DEDUCTIBLE means as shown in the Schedule of Insurance is a deductible applied in addition to the Specific Deductible. At the start of a Policy Period, Plan Benefits for each Covered Person in Excess of the Specific Deductible will be added together until the cumulative total equals the Aggregating Specific Deductible amount shown in the Schedule of Insurance. A Specific Excess Loss reimbursement will not be paid by the Company until the Aggregating Specific Deductible has been satisfied.

AGGREGATE DEDUCTIBLE for any one Policy Period means the greater of:

(1) The cumulative monthly total of Covered Units multiplied by the Monthly Aggregate Factors; or

(2) The Minimum Aggregate Deductible.

APPLICATION means the complete and total application made by the Policyholder, including census data, Plan Document, disclosure statements, conditional covernote, and any other information submitted by the Policyholder for the purpose of determining the Company's liability under this Policy.

BENEFIT PERIOD means the period of time in which a claim must be Incurred by the Covered Person and Paid by the Plan to be eligible for reimbursement under this Policy. This period does not alter the Policy Effective Date and Policy Period.

COMPANY means the underwriting company who is a member of the ACE Group of Companies and is the company underwriting this Policy.

COVERED PERSON means any one individual entitled to benefits under the Policyholder's Plan.

COVERED UNIT for the purposes of determining the premiums payable or the Aggregate Deductible means the following Covered Person:

(1) Employee;

(2) Employee with dependents; or

(3) Such other defined unit as agreed between the Company and the Policyholder.

EXPERIMENTAL OR INVESTIGATIONAL TREATMENT means a treatment, procedure, service, device, or drug (treatment) which will be considered to be experimental or investigational if:

1. The treatment has not been approved by the United States Food and Drug Administration (FDA) at the time the treatment is provided; or
2. The treatment is identified as a Phase I, II, III, or IV clinical trial or under study to determine its maximum tolerated dose, its safety, its efficacy, or its toxicity as compared with the standard means of treatment or diagnosis; or
3. The treatment is governed by a written protocol that references determinations of safety, toxicity and/or efficacy in comparison to conventional alternatives and/or has been approved or is subject to the approval by an Institutional Review Board (IRB) or the appropriate committee of the provider institution; or
4. The treatment is being provided subject to the Covered Person's execution of an informed consent that references determinations of safety, toxicity or efficacy in comparison to conventional alternatives; or
5. The predominant opinion of medical experts as expressed in published peer-reviewed literature is that further research is necessary in order to determine safety, toxicity, or efficacy in comparison to conventional alternatives.

Experimental or Investigational Treatment will be considered an Eligible Claim Expense under this Policy when the following criteria are met:

1. Treatment protocol identified as a Phase II, III, or IV clinical trial, or the equivalent, will be considered an Eligible Claim Expense when all of the following criteria are met:
   a) There is no clearly superior, non-investigational treatment alternative and there is a reasonable expectation that the treatment will be more effective than the non-investigational alternative; and
   b) The clinical trial is subject to review by an IRB and has been approved by the governing local IRB; and
   c) The Covered Person has executed an informed consent, which has been approved by the IRB; and
   d) The treatment protocol has been approved by one or more of the following organizations, the treatment is being provided within one of the centers designated by the clinical trial sponsor as a participating center and is being provided under the direction of the principal investigator at that center:
      i. National Institutes of Health (NIH).
      ii. NIH cooperative group or center.
      iii. United States Department of Health and Human Services (HHS), which includes the Center for Medicare and Medicaid Services (CMS).
      iv. FDA.
      v. United States Department of Defense.
      vi. United States Department of Veterans Affairs; or
2. Treatment utilizing drugs previously approved by the FDA for non-approved indications when all of the following criteria are met:
   a) There is no clearly superior, non-investigational treatment alternative and there is a reasonable expectation that the treatment will be more effective than the non-investigational alternative.
   b) The provider has complied with all of the IRB's requirements for providing the treatment; or
3. Treatment utilizing Investigator sponsored trials which are done in accordance with IRB approved protocols in an academic medical center that is a recipient of NIH grants and which meets all of the criteria in 1.(a) through 1.(d) above. Investigator sponsored trials will be considered on a case-by-case basis. Investigator or drug company sponsored trials in which there is no academic medical center involvement and where the principal investigator is not affiliated with an academic medical center will not be considered for coverage except by recommendation of an independent third party reviewer. To determine if any treatment meets the standards for coverage, the Company reserves the right to obtain an independent third party review.

INCURRED means a Plan Benefit will be considered Incurred as follows:
(1) with respect to services, the date on which the services are rendered to the Covered Person; or
(2) with respect to supplies, the date on which the supplies are given to the Covered Person; or
(3) with respect to disability income benefits, if covered, on the date each periodic benefit payment becomes payable to the Covered Person.

LIFETIME LIMIT OF LIABILITY PER COVERED PERSON means the maximum amount the Company will reimburse the Policyholder under this Policy or any policy issued by the Company prior to or later than this Policy providing Excess Loss Insurance benefits for Plan Benefits payable on behalf a Covered Person. The Lifetime Maximum does not include the amount of any Plan Benefits used to satisfy the Specific Deductible or Aggregating Specific Deductible. It will not exceed the lesser of: the amount shown in the Schedule of Insurance, or the lifetime maximum amount set forth in the Plan.

MONTHLY AGGREGATE FACTOR means the factors that are multiplied by the number of Covered Units for each Policy Month to determine the Annual Aggregate Deductible. The Monthly Aggregate Factors are shown in the Schedule of Insurance.

PAID means Plan Benefits will be considered Paid on the date that the Policyholder's check or draft is issued, subject to the following:
(1) there are sufficient funds to cover such check or draft; and
(2) the check or draft is placed in the United States mail or other means of delivery to the payee; and
(3) the check or draft it is honored upon presentation by the payee; or
(4) payment is successfully transmitted electronically from the payor's account to the payee's account.

Checks or drafts which are prepared but are not released or which do not adhere to the requirements immediately above shall not be considered Paid.

PLAN means the Policyholder's self-funded benefit plan as described in its signed Plan Document and all signed Amendments and Endorsements thereto that were underwritten and approved by the Company for issuance of this Policy. A copy of the Plan Document and Amendments approved by the Company are attached to this Policy for the purpose of determining the Company's liability under this Policy.

PLAN BENEFITS means the amounts properly Incurred and Paid under the Plan to a Covered Person or to a provider of services to a Covered Person.

Plan Benefits do not include the following:

(1) Payments not strictly in compliance with the terms and conditions of the Plan; or

(2) Any amount for which there is any other group insurance, reinsurance, plan benefits, including insurance or plan benefits established pursuant to federal, state or local legislation or regulation; or

(3) Court costs, penalties, interest upon judgments, investigation expense, administrative fees, or legal expense; or

(4) Fees applicable to the proper administration of the Plan; or

(5) Exemplary and punitive damages or liabilities, including but not limited to those resulting from negligence, intentional wrongs, fraud, bad faith or strict liability on the part of the Policyholder or the Policyholder's agent.

(6) Expenses which are not considered medically necessary; or Experimental or Investigational Treatment; or expenses which are not recognized by the Food and Drug Administration of the United States Government; or expenses which are outside the scope of generally accepted standards of medical practice.

PLAN DOCUMENT means the current written expression of the Policyholder's self-funded benefit Plan.

POLICY means this Policy issued to the Policyholder.

POLICY PERIOD means the specified period in the Schedule of Insurance, however, beginning no earlier than the Effective Date of this Policy and continuing until coverage terminates in accordance with the Termination provision of this Policy.

PROVIDER NETWORK means a network or similar organization consisting of selected health care providers (e.g. physicians and hospitals) that provide services or supplies to a covered person at a discounted or pre-determined price.

REASONABLE AND CUSTOMARY CHARGES means the normal charge made to an individual without insurance and which does not exceed the general level of fees and prices normally charged for a given procedure or supply within the same geographical area in which the expense was Incurred. The Reasonable and Customary Charge will be determined by the Company based upon the most current version of the Reasonable and Customary Fee Schedules maintained by the Policyholder's Third Party Administrator. In no event will the allowable charge exceed: 1) the amount charged to an individual without insurance; or 2) the Provider Network discounted or pre-determined price; or 3) the 90th percentile of the most current version of the Reasonable and Customary Fee Schedules maintained by the Policyholder's Third Party Administrator, whichever is less.

RUN-IN EXPENSES means Plan Benefits Incurred during the Benefit Period, but prior to the Policy Period.

RUN-IN LIMIT means the maximum amount of Run-In Expenses that will be applied to this Policy.

RUN-OUT EXPENSES means Plan Benefits Paid during the Benefit Period, but following the Policy Period.

RUN-OUT LIMIT means the maximum amount of Run-Out Expenses that will be applied to this Policy.

SPECIFIC AGGREGATE DEDUCTIBLE means the amount of Plan Benefits that is retained and paid by the Policyholder during the Policy Period. This amount is not reimbursable under this Policy. The Specific Aggregate Deductible applies separately to each Covered Person. It is shown in the Schedule of Insurance.

TERRORISM OR TERRORIST ACTS means an activity that 1) involves any violent act or any act dangerous to human life, tangible or intangible property, and that threatens or causes damage to property or Injury to persons, and 2) appears to be in any way intended to: a) intimidate or coerce a civilian population; or b) disrupt any segment of a nation's economy; or c) influence the policy of a government by intimidation or coercion; or d) affect the conduct of a government by mass destruction, assassination, kidnapping or hostage-taking; or e) respond to

governmental action or policy. It includes the use of any nuclear weapon or device or the emission, discharge, dispersal, release or escape of any solid liquid or gaseous chemical or biological agent. It shall also include any incident declared to be an act of terrorism by an official, department or agency that has been specifically authorized by federal statute to make such a determination.

THIRD PARTY ADMINISTRATOR means a firm or person shown in the Schedule of Insurance that has been retained by the Policyholder to pay claims and/or provide other administrative services on behalf of the Policyholder.

SPECIFIC EXCESS LOSS

The Company will reimburse the Policyholder for the amount of eligible Plan Benefits which exceed the Specific Deductible on a Covered Person during the Policy Period. Such reimbursement will be made in accordance with Benefit Period and all other coverage provisions, limitations and exclusions as shown in the Schedule of Insurance and in this Policy. In order for eligible Plan Benefits to be considered for reimbursement under this Policy, an initial Proof of Loss satisfactory to the Company must be received by the Company no later than 60 days after the date Plan Benefits are Paid in excess of the Specific Deductible. No claim will be reimbursed until satisfactory information has been provided.

While the determination of benefits under the Plan is the sole responsibility of the Policyholder, the Company reserves the right to interpret the terms and conditions of the Plan as it applies to this Policy. The Company has the sole authority to approve or deny reimbursements under this Policy.

AGGREGATE EXCESS LOSS

The Company will reimburse the Policyholder for the amount of eligible Plan Benefits which exceed the Aggregate Deductible during the Policy Period. Such reimbursement will be made in accordance with the Benefit Period and all other coverage provisions, limitations and exclusions as shown in the Schedule of Insurance and in this Policy. Plan Benefits on each Covered Person in excess of the Loss Limit Per Person under Aggregate will not be included for purposes of determining the amount of the Aggregate Excess Loss reimbursement under this Policy.

Reimbursements to the Policyholder for any Aggregate Excess Loss provided under this Policy will be made after the end of the Policy Period provided:
(1) the Company has received all of the information it requires (Proof of Loss); and
(2) the Company has completed any audit it may deem necessary.

In order for eligible Plan Benefits to be considered for reimbursement under this Policy, an initial Proof of Loss satisfactory to the Company must be received by the Company no later than 60 days after the end of the Policy Period. No claim will be reimbursed until satisfactory information has been provided.

While the determination of benefits under the Plan is the sole responsibility of the Policyholder, the Company reserves the right to interpret the terms and conditions of the Plan as it applies to this Policy. The Company has the sole authority to approve or deny reimbursements under this Policy.

If this Policy is terminated prior to the end of the Policy Period, the Aggregate Deductible will not be prorated.

TERM OF POLICY

This Policy will be in force during the Policy Period shown in the Schedule of Insurance and will automatically terminate at the end of the Policy Period unless it has been terminated earlier as provided in TERMINATION, or unless the Company and the Policyholder have agreed upon terms to renew the Policy. In such event, the Company will issue to the Policyholder a Renewal Endorsement and renewal Schedule of Insurance. If the Policy is terminated before the end of the Policy Period stated in the Schedule of Insurance, the Company has no obligation to reimburse the Policyholder for any Plan Benefits that are paid after the date the Policy is terminated.

LIMITATIONS

If the Policyholder fails to disclose any required health information on:
1. a Covered Person when application is made for this Policy; or
2. on an employee, or a dependent of an employee, who later becomes eligible for Plan Benefits

then:

1. The Company will not reimburse the Policyholder for any Plan Benefits related to the illness or condition that was required to be disclosed; and
2. Such Plan Benefits paid by the Plan may not be used to satisfy the Specific Deductible for such Covered Person; and
3. Such Plan Benefits paid by the Plan may not be used to satisfy the Aggregate Deductible.

The Company will reimburse Plan Benefits for Retired Employees and their eligible dependents who are covered under the Plan only if such Persons are indicated as included in the Schedule of Insurance.

The Company will reimburse Plan Benefits for persons qualifying for COBRA continuation benefits only if the Policyholder makes timely notification to such individuals of their rights to continue Plan coverage under COBRA.

Any reimbursement of Plan Benefits for a Covered Person eligible for coverage under Medicare shall be reduced by any amount paid or payable under Medicare to the extent any reimbursement under this Policy for a Covered Person or his or her dependents shall not exceed 100% of the actual expenses otherwise reimbursable under the Policy.

EXCLUSIONS

The following charges and/or expenses are not covered:

The Company will not reimburse Plan Benefits for any of the following:

(1) Claim payments for services, treatment, medicine or drugs related to any of the following circumstances:
   a) Self-inflicted injury or illness.
   b) Declared or undeclared war or act of war, whether civil or international, and any substantial armed conflict between organized government forces of a military nature.
   c) Felony, riot or civil disobedience.
   d) Illness or injury caused by or resulting from invasion, acts of foreign enemies, hostilities, civil war, rebellion, insurrection, military or usurped power, or martial law or confiscation by order of any government or public authority, except to a Covered Person bystander or where such coverage is mandated by Federal regulation.
   e) Injury or illness to a Covered Person which occurs during the commission of or attempt to commit a criminal act or while a Covered Person is engaged in an illegal activity.
   f) Terrorism or Terrorist Acts.
   g) Custodial care.
   h) Sex reassignment

(2) Any claim payment for expenses incurred in any of the following circumstances:
   a) While a Covered Person is serving on full-time active duty in any armed forces.
   b) By an individual who is not a Covered Person under the Plan when the expense is incurred.
   c) When the Plan is not in effect.
   d) For expenses of persons who are not reported on the Policyholder's disclosure statement who should have been disclosed in compliance with the Policyholder's disclosure statement.
   e) To the extent the Policyholder receives payments for those expenses from other insurers or to the extent the Policyholder is not liable for expenses covered under Medicare or another health insurance plan.
   f) Expenses also covered as benefits under Medicare or another health insurance plan. In no event will total payments on behalf of a Covered Person for a reimbursement otherwise payable under this Policy and any similar Medicare benefit or a benefit under another health insurance plan exceed 100% of the Covered Person's eligible claim expenses.
   g) In excess of the charges the Company determines are Reasonable and Customary Charges.
   h) For Experimental or Investigational Treatment or any procedure held to be Experimental or Investigatory by the Company at the time the procedure is done.
   i) For an organ transplant or implant of non-human, artificial or mechanical organs.
   j) Arising from ionizing radiations, pollution or contamination by radioactivity from any nuclear waste from the combustion of nuclear fuel and the radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.

(3) Claim payments not administered or paid according to the Plan, or for which there is no documented proof of loss.

(4) Any claim payment, or portion of a claim payment for any of the following expenses:
   a) Deductibles, co-payment amounts, or any other charges which are not payable under the terms of the Plan or charges which are payable from another source.
   b) Legal expenses, fines, penalties, damages, judgments or other penalties imposed by law.
   c) Expenses covered by any workers' compensation act or other law covering occupational injuries or disease.
   d) Loss or expense caused by or resulting from occupational injury or sickness benefits. This exclusion shall also apply if the Covered Person is entitled to insured or self-funded coverage for such expenses under any Worker's Compensation, Employer's Liability or Occupational Disease statute, whether or not such coverage is actually in force.
   e) Expenses related to any occupation or employment for wage or profit.
   f) Any claim payment for expenses resulting from dental, vision, prescription drug programs, unless shown in the Schedule of Insurance as a covered expense.

(5) Any claim payments for cosmetic services, unless performed as soon as medically feasible and necessary for any of the following conditions:
   - An illness or injury that occurs while covered under the Plan,
   - Reconstruction that is incidental to or follows surgery resulting from an injury or illness,
   - The correction of a functional defect, or
   - The correction of a congenital defect that results in a functional defect of a covered child born while the employee is covered by the Plan.

(6) A claim for any expenses that are not Medically Necessary and Appropriate. Medically Necessary and Appropriate means that a service, supply or drug is: 1) provided by a recognized provider; 2) accepted by the U.S. Food and Drug Administration; and 3) generally accepted as the standard of care for the control or cure of the illness or injury being treated by physicians in the same or related specialty fields.

(7) Expenses for any individual covered under, or eligible for coverage under, the Consolidated Omnibus Reconciliation Act (COBRA) whose continuation of coverage was not offered in accordance with COBRA regulations or any amendments thereto.

(8) Expenses incurred as a result of any lost savings or discounts offered by a facility or provider due to untimely payment of the bill by the Plan, Policyholder or Third Party Administrator.

(9) Provider retention costs and administrative fees shall not be considered Plan Benefits eligible for reimbursement under the Policy. These expenses may not be used to satisfy the Specific Deductible and/or Aggregate Deductible shown in the Schedule of Insurance. Provider standard discounts must be applied to all Plan Benefits applied to the Specific Deductible and/or Aggregate Deductible under the Policy.

(10) Capitated Services and Fees shall not be considered Plan Benefits eligible for reimbursement under the Policy. "Capitated Services and Fees" mean a fixed, predetermined amount paid to a provider for each person covered, without regard to the actual services provided to each person in a set period of time. The Company must be notified in writing of the removal of any capitated program during the Policy Period. Removal of a capitated program will be considered a change to the Plan.

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit Us from providing insurance, including, but not limited to, the payment of claims.

PREMIUMS AND AGGREGATE FACTORS

The Schedule of Insurance shows the Premium Rates and Aggregate Factors for each Plan Benefit provided coverage under this Policy. The initial premium is due on the Effective Date of this Policy and subsequent premiums are due the first day of each succeeding month in the Policy Period. The entire amount of the applicable

premium shall be paid when due. The Company is not obligated to accept or apply any premium paid which is less than the entire amount due for any period. Premium payments shall be credited first to any past due and unpaid premium, in the order in which due. Premiums are not considered paid until the premium payment is received by the Company.

A grace period of 31 days is allowed for the payment of any premium except the first. The Company is not obligated to apply any premium which is received after the grace period and may return any premium payment. The payment of any premium will not cause the insurance under this Policy to remain in force beyond the day before the next Premium Due Date.

The Company may change the premiums and Aggregate Factors on any of the following dates:

(1) The effective date that the Plan is amended; or

(2) The effective date that the Policyholder adds or deletes subsidiary or affiliated companies or divisions; or

(3) The date an increase or decrease in the number of Covered Units exceeds 10% in any one month or 25% over any period of three consecutive months; or

(4) The date the monthly Paid Aggregate claims total of the current Policy Period exceed the average monthly Paid claim total of the prior six (6) months by more than 20%; or

(5) The date that the Company is informed of a Clerical Error or discovers material misrepresentation of underwriting information. The Company's action will be accordance with the Misstated Data Provisions under GENERAL PROVISIONS of this Policy.

The Policyholder will furnish to the Company any information which the Company deems is necessary to allow the Company to determine the amount of premium due under this Policy. The Company may examine any records of the Policyholder at any reasonable time to confirm that premiums are being calculated and paid in accordance with this Policy.

The Company will refund to the Policyholder any overpayment of premium made in error. Such refund shall be made only for the overpayments made during the Policy Period in which the error is uncovered and reported to the Company.

CLAIM PROVISIONS

Administration of Claims Under the Plan

The Company will have no obligation under the terms of this Policy for the settlement of claims Incurred by Covered Persons.

The Policyholder warrants, upon presentation of a Plan Benefit for reimbursement, that all monies necessary to pay for the Plan Benefit have been Paid to the Covered Person or the provider of services to the Covered Person.

The Policyholder will pay each claim Incurred under the Plan by a Covered Person within sixty (60) days that adequate proof of loss is provided to the Policyholder's Plan. If the Policyholder fails to pay the claim within this time limit, then this claim will not be a covered Plan Benefit under this Policy. **The Policyholder will provide funds necessary to pay claims and failure to do so will cause this Policy to automatically terminate as provided for in Termination.**

The Policyholder will maintain records showing the complete details concerning any and all amounts Paid for benefits not provided under the terms of the Plan. These payments for benefits not provided will not be included in determining Plan Benefits reimbursable under this Policy.

No reimbursements will be made under this Policy for losses for which the Policyholder is not legally obligated to pay or for payments for services which are not covered under the Plan.

Proof of Loss

The Policyholder will give written notice of claims to the Company on the Company's customary proof of loss form within thirty (30) days of the date the Policyholder becomes aware of the existence of facts that would reasonably suggest the possibility that Plan Benefits will be Incurred which are subject to this Policy or which are at least fifty (50)% of the Specific Deductible. The Policyholder will also comply with other claim reporting requirements,

provided that the Company sends written notice to the Policyholder of these requirements and allows the Policyholder thirty (30) days to begin complying with the new requirements.

Failure to furnish written notice will not invalidate or reduce any claim, if it was not reasonably possible to provide such written notice within the time period required. However, in no event will the Company be liable for any claims submitted for reimbursement more than twelve (12) months after the end of the Policy Period.

Reports and Audits

The Policyholder will submit, within 15 days of the Company's request, reports and supporting documents requested by the Company, including but not limited to, periodic estimates of claims pending under the Plan and a monthly summary of all eligible claim payments processed by the Policyholder and the total number of Covered Units covered under the Plan during the prior month. The Policyholder will be responsible for the investigating, auditing, calculating and paying all claims Incurred under the Plan.

Independent Review

In the event that eligible Plan Benefits are deemed payable by the Plan due to a reversal by an Independent Review Organization of a previous denial of coverage, and such eligible Plan Benefits are not paid within the Benefit Period under this Policy, the Benefit Period to pay such eligible Plan Benefits will be extended for a period of 12 months from the end of the Benefit Period shown in the Schedule of Insurance, provided: 1) such Plan Benefits are not eligible under any other coverage; and 2) such Plan Benefits would otherwise be payable under the terms of this Policy.

Subject to all other terms and conditions of this Policy, the Company agrees to accept as eligible claim expenses all such Plan Benefits paid in accordance with the Plan that were previously denied and exceed the applicable deductible.

When the Company reimburses the Policyholder for the amount of any Plan benefits payable under this provision, such Plan benefits will relate back to the Policy under which they were Incurred and will be excluded from any other Benefit Period.

If the Policyholder terminates this Policy for any reason prior to the end of the Policy Period shown in the Schedule of Insurance, this provision does not apply.

TERMINATION

By the Policyholder

The Policyholder may terminate this Policy on any Premium Due Date by giving the Company at least 31 days advance written notice.

By the Company

At its option, the Company may terminate this Policy on the date that any one of the following occurs:

(1) the date it is determined that the Policyholder has failed to perform any of its duties or obligations under this Policy; or

(2) the date a petition in bankruptcy is filed with respect to the Plan or the Policyholder, whether voluntary or involuntary, or the Plan or the Policyholder become subject to liquidation, receivership or conservatorship.

Automatic

This Policy will automatically terminate without notification required upon the earliest of the following dates:

(1) The date the Policyholder's Plan terminates; or

(2) The end of any grace period when the premium due remains unpaid; or

(3) The date the Policyholder has failed to provide funds for payment of claims under the Plan; or

(4) Delegation by the Policyholder of its duties under this Policy to a Third Party Administrator which has not been approved by the Company; or

(5) Whenever the percentage of employees participating in one or more Health Maintenance Organizations, prepaid plans, or insurance plans exceeds 40% of employees eligible to participate in the Plan, unless the Company has agreed in writing to continue coverage; or
(6) The date the Plan is found to be in violation of Federal law; or
(7) Sixty (60) days after the Effective Date if the Policyholder has failed to furnish the Company with any information or materials requested by the Company. Such information or materials must be of reasonable nature to allow the Company to determine the risk assumed under this Policy. If the Policy is rescinded for this cause, the Company's sole liability will be to return any monies given by the Policyholder as consideration for this Policy and less any claims or other expenses paid by the Company under this Policy. If such amounts paid by the Company are greater than the amount of the refund due the Policyholder, the Policyholder shall pay the amount of the deficit to the Company within thirty days of notice from the Company. If repayment in full is not made within this thirty day period, the Company will be entitled to assess monthly a late payment fee equal to 1.5% of the outstanding balance.

Effect of Termination

In the event this Policy is terminated prior to the end of the Policy Period, the Deductible amounts shown in the Schedule of Insurance will not be prorated. The Specific and Aggregate Deductibles will be applied as if the Policy had remained in effect for the entire original Policy Period. The Company will not refund any portions of premium paid by the Policyholder whose Plan terminated during the Policy Period.

The Company has no obligation to reimburse the Policyholder for any Plan Benefits that are Paid after the date this Policy is terminated.

GENERAL PROVISIONS

Entire Policy
The entire Policy consists of this Policy, the attached copy of the Policyholder's Application, the Plan and Policyholder disclosure statement, and any amendments, riders or endorsements.

Changes to the Policy
This Policy may be changed at any time by a written agreement between the Policyholder and the Company. The provisions of this Policy may be changed or waived only by the President, a Vice President or the Secretary of the Company and only in writing. The Company will not be bound by any promise or representations made by any other person.

The Company may, at any time, change any one or more or all of the items shown in the Schedule of Insurance by endorsement during the Policy Period if a change is made to any applicable state or Federal law that, in the sole opinion of the Company, may affect the Company's liability under this Policy.

Parties to the Policy
This Policy is a contract between the Policyholder and the Company. This Policy does not create any right or legal relationship between the Company and any person covered under the Plan. The Company's sole liability under this Policy is to the Policyholder. Any and all reimbursements payable under this Policy will be made solely to the Policyholder. This policy will not be deemed to make the Company a party to any contract or agreement between the Policyholder and a third party.

Plan Document
The Policyholder will provide to the Company a complete copy of the Plan Document governing the Plan; such Plan Document will be made part of this Policy. The Policyholder will submit to the Company, in writing, any proposed change to the provisions of the Plan. This writing must be submitted to the Company at least thirty (30) days prior to the effective date of the proposed change. The Company will have the right to modify premium rates and/or other terms and conditions of coverage if the Company determines that its liability under this Policy has been affected by the change in the Plan. If the Company and the Policyholder cannot reach agreement with respect to the Plan changes, the Plan change will not affect the Company's liability under this Policy and the Policy will be administered as if the Plan had not changed. The Company's liability under the Policy will not be affected by any such charges made to the Plan unless and until the Company has sent its written approval of such changes to the Policyholder or its agent.

Third Party Administrator
The Policyholder may retain a Third Party Administrator to perform some or all of its duties under this Policy. Such Third Party Administrator must be named in the Schedule of Insurance. The Third Party Administrator must be approved by the Company to perform the Policyholder's duties under this Policy. The Policyholder will provide to the Company a copy of its agreement with the Third Party Administrator as well as a copy of changes thereto. These documents are NOT made part of this Policy.

Without waiving any of its rights under this Policy, and without making the designated Third Party Administrator a party to this Policy, the Company agrees to recognize the Third Party Administrator as the agent for the Policyholder. Any action or inaction by the Third Party Administrator will be deemed to be the action or inaction of the Policyholder. The Third Party Administrator is NOT the agent of the Company. Notwithstanding its appointment of a Third Party Administrator, the Policyholder is still obligated to see to the timely performance of its duties and obligations under this Policy. Furthermore, the Policyholder will hold the Company harmless from any liability arising from or related to any negligence, error, omission or malfeasance by the Third Party Administrator.

The Policyholder may change its Third Party Administrator. Notice of a change in the Third Party Administrator is subject to the Company's approval and must be submitted in writing to the Company at least sixty (60) days prior to the effective date of change. Any changes to the designated Third Party Administrator without prior written approval by the Company will cause this Policy to automatically terminate as provided for in TERMINATION.

Reporting
The Policyholder will furnish the Company with any information required by the Company pertaining to the risks covered under this Policy. Such information must be received by the Company in a form and during a time period satisfactory to the Company.

Records
The Policyholder will maintain all records of the Company during the Benefit Period and for a period of seven (7) years after termination of the Policy. The Policyholder will make all such records available to the Company as needed for the Company to determine its liability under this Policy.

Audit
The Company or its authorized representative will have the right to audit, at its own expense, the records of the Policyholder, the Third Party Administrator or any other person or entity who is responsible for the administration of the Plan pertaining to the matters which affect the Company's liability under this Policy. The Policyholder agrees that payment of any reimbursements under this Policy will be conditioned upon the results of any audit requested by the Company.

Clerical Error
Clerical error, whether by the Policyholder or the Company, in keeping any records pertaining to the coverage, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated. Any clerical error in data that the Policyholder or its agent provided to the Company must be corrected and promptly reported to the Company. The Company will within fifteen (15) days of receipt of corrected data decide the corrective course of action under the terms of Misstated Data provision below.

Concealment, Fraud
This entire Policy will be void:

(1) if, before or after making any reimbursement, the Company determines that the Policyholder or its agent has concealed or misrepresented any material fact or circumstance concerning this Policy, including any losses under the Plan; or

(2) in any case of fraud by the Policyholder or its agent.

Misstated Data
The Company has relied upon the underwriting information provided by the Policyholder or its agent in the issuance of this Policy. If subsequent information becomes known which, if known by the Company prior to the issuance of this Policy, would have affected the premium rates, aggregate factors, specific or aggregate deductibles, terms or any other conditions for coverage, the Company will have the right to adjust the premium rates, aggregate factors, specific or aggregate deductibles, terms or any other conditions for coverage as of the Effective Date by providing

written notice to the Policyholder. If the Policyholder rejects any new adjustment or condition imposed, the Company can rescind the Policy as of the Effective Date.

In the event of Policy rescission, the Company's sole liability will be to return any monies given by the Policyholder as consideration for this Policy and less any claims or other expenses paid by the Company under this Policy. If such amounts paid by the Company are greater than the amount of the refund due the Policyholder, the Policyholder shall pay the amount of the deficit to the Company within thirty days of notice from the Company. If repayment in full is not made within this thirty day period, the Company will be entitled to assess monthly a late payment fee equal to 1.5% of the outstanding balance.

Insolvency
The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder or its Third Party Administrator will not impose on the Company any liability other than the liability defined in this Policy. The insolvency of the Policyholder will not make the Company liable to the creditors of the Policyholder, particularly the Covered Persons under the Plan.

Liability
The Company will not have any obligation or power under this Policy to directly pay any Covered Person or any provider of services or supplies to a Covered Person. The Company's sole liability is to the Policyholder. Nothing in this Policy will be construed to permit a Covered Person or any provider of services or supplies to a Covered Person to have a direct right of action against the Company. The Company is not a party to the Plan or to any modifications thereto. The Policyholder may not assign reimbursements under this Policy and the Company will not recognize any such assignments.

Recoveries/Subrogation
The Policyholder is required to investigate and prosecute all valid claims it may have against third parties arising out of any claim for Plan Benefits. The Company will require an accounting of all amounts recovered from these third parties. If the Policyholder fails to pursue any action against a third party and the Company has made reimbursements for the claim under this Policy, the Company will be subrogated to the Policyholder's rights to make recoveries. In this event, the Policyholder is required to cooperate fully and do all the things necessary and required for the Company to pursue an action to recover against the third party.

Any amounts recovered by the Policyholder, its Third Party Administrator, or a Covered Person in such action shall be used to first reimburse the Company for any benefit payments made on behalf of any Covered Person, and then to reimburse the expenses of recovery. Any amounts recovered by the Company shall be used to reimburse the Company for any amount it may have paid or become liable to reimburse the Policyholder under the terms of this Policy, and then to reimburse the Company's expenses of collection. All remaining amounts shall be paid to the Policyholder. If the Company reimburses the Policyholder for all or part of a particular loss and the Policyholder or the Plan later recover for that loss from a third party, the Policyholder must repay the Company to the extent of its reimbursements, regardless of whether this Policy is still in force on the date of the recovery.

In the event the Policyholder or its Third Party Administrator do not consider a third party to be liable for certain claims under the Plan but the Company does, the Company shall be subrogated to all of the Policyholder's recoveries for such claims.

Notice of Appeal
The Company must promptly receive written notice of any objection, notice of legal action or Insurance Department complaint received on a claim processed under the Plan on which it reasonably appears a reimbursement under this Policy will be payable.

Taxes
The payment of reimbursements under this Policy will not include:
(1) any taxes which might be paid or payable by the Policyholder; or
(2) any tax liability, interest or penalty imposed by any regulatory or taxing authority.

The Policyholder agrees to:
(1) hold harmless the Company from any tax liability assessed against the Company on the basis of the coverage provided under the Plan other than any tax levied upon the Company for the premium due under this Policy; and

(2) reimburse the Company for the amount of any such tax liability, interest, penalty or cost incurred by the Company as the result of such tax assessment. Such reimbursement shall be due and payable when the Policyholder receives the Company's notification that reimbursement is due.

Notice

For the purpose of any notice required from the Company under the provisions of this Policy, notice to the Third Party Administrator will be considered notice to the Policyholder, and notice to the Policyholder will be considered notice to the Third Party Administrator. For the purpose of any notice requirement from the Policyholder under the provisions of this Policy, neither notice from the Policyholder to the Third Party Administrator nor notice from the Third Party Administrator to the Policyholder will be considered notice to the Company. Notice from the Policyholder must be sent to the Company or its authorized representative.

Other Insurance

The amounts otherwise payable under this Policy shall be reduced by the amount of any other reimbursement or indemnity which the Policyholder may be entitled to receive with respect to the Company's liability under this Policy.

Waiver

Failure of the Company to strictly enforce its rights under this Policy shall not waive any such right, regardless of the frequency or similarity of the circumstances.

ACE American
Insurance Company
(A Stock Company)
Philadelphia, PA 19106

Specific Advanced Funding Option Endorsement

POLICY ENDORSEMENT

TO BE ATTACHED TO AND MADE A PART OF POLICY NO. N10843534
ISSUED TO HOUSING AUTHORITY OF THE CITY OF EL PASO

BY ACE AMERICAN INSURANCE COMPANY

Effective Date: **July 01, 2015**

This Endorsement Is made a part of the Policy to which it Is attached as of the Effective Date shown above. It applies only to Plan Benefits Incurred and Paid on or after that date. If no Effective Date is shown above, this Endorsement takes effect as of the Policy Effective Date. This Endorsement is subject to all of the terms, limitations and exclusions of the Policy except as they are changed by it.

Any changes in premium apply as of the first premium due date on or after the effective date of this Endorsement.

The Policy has been changed as follows:

Specific Advanced Funding Option

The Company will expedite reimbursement of Specific Excess Loss benefits for Plan Benefits Incurred in excess of the Specific Deductible prior to the Plan's actual payment of these benefits. In order for benefits to be payable under this Endorsement, the required premiums due under the Policy must be paid current

In order to request Specific Advanced Funding, the Policyholder must:

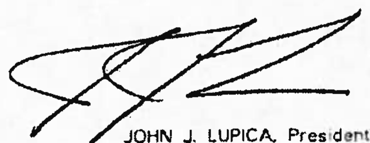
1) Process all claims for the Covered Person and print the detailed Explanation of Benefits;
2) Fund claims up to the full amount of the Covered Person's Specific Deductible plus a minimum threshold of a cumulative $2,000 in claims in excess of the Specific Deductible in order to satisfy the required reimbursement of claims;
3) Have paid all premiums current for the Policy Period in question;
4) Complete and submit a Specific Excess Loss claim requesting Specific Advanced Funding and attaching all required filing documentation.

Failure of the Policyholder to follow the filing guidelines outlined above will result in a delay in receiving reimbursement.

If the Policyholder terminates the Policy prior to the end of the Policy Period, effective immediately the Specific Advanced Funding Option will no longer be available and no Specific Excess Loss benefits will apply for Plan Benefits Paid after the termination date

This Endorsement ends at the same time as the Policy to which it is attached.

Signed for ACE AMERICAN INSURANCE COMPANY at Philadelphia, Pennsylvania



JOHN J. LUPICA, President

REBECCA L. COLLINS, Secretary

SPECIFIC EXCESS LOSS

SPECIFIC COVERAGE: Yes ☒ No ☐ **Specific Deductible:** $250,000

Policy Period Limit of Liability per Covered Person (Less Specific Deductible): Unlimited

Lifetime Limit of Liability per Covered Person: Unlimited

Claims Basis: 24/12 Incurred in 24 Months and Paid in 12 Months (12 Month Run-in)

Benefit Period:
Eligible Plan Benefits Incurred from: July 01, 2014 through June 30, 2016 and Paid through: July 01, 2015 through June 30, 2016

Specific Percentage Reimbursable After Deductible: 100%

Aggregating Specific Deductible* :$N/A (*Estimated – Minimum will be set based upon actual enrollment and subject to year-end Reconciliation.)

If the Policy is terminated before the end of the Policy Period stated above, the Company has no obligation to reimburse the Policyholder for any Plan Benefits that are Paid after the date the Policy is terminated.

AGGREGATE EXCESS LOSS

AGGREGATE COVERAGE: Yes ☒ No ☐

Claims Basis 24/12 Incurred in 24 Months and Paid in 12 Months (12 Month Run-in)

Benefit Period:
Eligible Plan Benefits Incurred from: July 01, 2014 through June 30, 2015 and Paid through: July 01, 2015 through June 30, 2016

Aggregate Percentage Reimbursable: 100%

Monthly Aggregate Factors: Single $823.84 Family $1,997.91

Minimum Aggregate Deductible: Based on Initial Covered Units times Monthly Aggregate Factors times number of months in Policy Period times 100%

Limit of Liability for the Policy Period: $1,000,000

Loss Limit Per Person under Aggregate $250,000

Run-In Limit $798,156

If the Policy is terminated before the end of the Policy Period stated above, the Company has no obligation to reimburse the Policyholder for any Plan Benefits that are Paid after the date the Policy is terminated.

PREMIUMS

SPECIFIC: Single: $24.88 monthly Family: $73.57 monthly
AGGREGATE: $5.90 Per Covered Unit Per Month

PLAN BENEFITS INCLUDED

SPECIFIC:
- ☒ Medical
- ☐ Dental
- ☐ Vision
- ☒ Prescription Drugs

AGGREGATE:
- ☒ Medical
- ☐ Dental
- ☐ Vision
- ☒ Prescription Drugs

ACE American Insurance Company
(A Stock Company)
436 Walnut Street
Philadelphia, PA 19106
1.800.352.4462

Application for Insurance Coverage

Applicant (Plan Sponsor): HOUSING AUTHORITY OF THE CITY OF EL PASO

Proposed Effective Date: July 01, 2015

Address: 5300 E. Paisano

Initial Premium Deposit: $ 17,898.73

City, State, Zip Code: El Paso, Texas 79905

Telephone Number: (915) 849-3785

Third Party Administrator: Meritain Health
8240 North Meridian Street
Suite 100
Indianapolis, IN 46260

Coverage Applied For:
☒ Specific Stop Loss
☒ Aggregate Stop Loss
☐ Other

Insurance applied for replaces prior coverage as follows:

Name of Company: Westport/Swiss RE

Type of Coverage: Medical Excess Loss

Termination Date: June 30, 2015

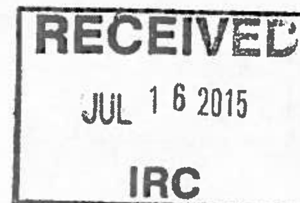
ACE American Insurance Company (the Company) acknowledges the receipt of an Application and deposit premium and issues this Conditional Covernote which states the coverage that the Company intends to provide, but only upon the satisfaction of the conditions listed under Section I. If these conditions are not satisfied within a 30 day period, all coverage is terminated as of that date. The Company's sole obligation to the proposed Policyholder will be to refund all unearned premium. If coverage is accepted by the Company, it will be subject to the terms and conditions of the Policy, and this Conditional Covernote will automatically be cancelled and superseded by the Policy as of the date it is issued.

I. CONDITIONS PRECEDENT TO THE BINDING OF COVERAGE:
Original Signed Large Claim Disclosure within 15 Days of the Proposed Effective Date along with all other contingencies as stated in the International Risk Consultants / ACE Proposal.

II. SCHEDULE OF INSURANCE

Initial Enrollment: **To be Based on the First Month's Premium Enrollment**

Policy Period: from July 01, 2015 through June 30, 2016



SCHEDULE OF INSURANCE

Initial Enrollment: Single **208** Family **138**

Policy Period: from **July 01, 2015** through **June 30, 2016**

SPECIFIC EXCESS LOSS

SPECIFIC COVERAGE: Yes ☒ No ☐ Specific Deductible: **$250,000**

Policy Period Limit of Liability per Covered Person (Less Specific Deductible): **Unlimited**

Lifetime Limit of Liability per Covered Person: **Unlimited**

Claims Basis: **24/12** Incurred in **24** months and Paid in **12** months **(12 month run-in)**

Benefit Period:
Eligible Plan Benefits Incurred from: **July 01, 2014** through **June 30, 2016** and Paid through: **July 01, 2015** through **June 30, 2016**

Specific Percentage Reimbursable After Deductible: **100%**

Aggregating Specific Deductible*: **$N/A** **(*Estimated – Minimum will be set based upon actual enrollment and subject to year-end Reconciliation.)**

If the Policy is terminated before the end of the Policy Period stated above, the Company has no obligation to reimburse the Policyholder for any Plan Benefits that are Paid after the date the Policy is terminated.

AGGREGATE EXCESS LOSS

AGGREGATE COVERAGE: Yes ☒ No ☐

Claims Basis **24/12** Incurred in **24** months and Paid in **12** months **(12 month run-in)**

Benefit Period:
Eligible Plan Benefits Incurred from: **July 01, 2014** through **June 30, 2016** and Paid through: **July 01, 2015** through **June 30, 2016**

Aggregate Percentage Reimbursable: **100%**

Monthly Aggregate Factors: Single **$823.84** Family **$1,997.91**

Minimum Aggregate Deductible: Based on initial Covered Units times Monthly Aggregate Factors times number of months in Policy Period times **100%**

Limit of Liability for the Policy Period: **$1,000,000**

Loss Limit Per Person under Aggregate **$250,000**

Run-In Limit **$798,165**

If the Policy is terminated before the end of the Policy Period stated above, the Company has no obligation to reimburse the Policyholder for any Plan Benefits that are Paid after the date the Policy is terminated.

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ACE American
Insurance Company
(A Stock Company)
436 Walnut Street
Philadelphia, PA 19106

Employer Stop Loss Insurance Policy

(This is a non-participating policy.)
Underwritten by
ACE American Insurance Company
P.O. Box 1000
436 Walnut Street
Philadelphia, PA 19106

This Policy is issued by **ACE American Insurance Company** (Company) to

Policyholder: **HOUSING AUTHORITY OF THE CITY OF EL PASO**

Policy Number: **N10843534**

Policy Effective Date: **July 01, 2015**

The Company agrees to reimburse the Policyholder for certain Plan Benefits the Policyholder has provided under a self-funded benefit plan (Plan). Such reimbursement will be subject to all the terms and conditions of this Policy.

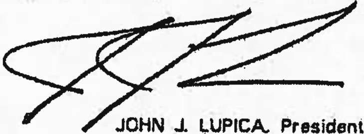
This Policy is issued in consideration of:
(1) the Application made by the Policyholder; and
(2) the payment of the initial premium on the Policy Effective Date of this Policy;
(3) the payment of all subsequent premiums when due; and
(4) the continual compliance by the Policyholder with all the terms and conditions of this Policy.

All periods of time under this Policy will begin and end at 12:01 A.M. local time at the Policyholder's address.

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

The provisions on the following pages are a part of this Policy

Signed for ACE AMERICAN INSURANCE COMPANY at Philadelphia, Pennsylvania


JOHN J. LUPICA President

REBECCA L. COLLINS, Secretary

The Policy provides benefits when the Policyholder's health plan has Incurred expenses beyond the individual and/or aggregate deductibles (whichever is applicable) outlined in the Policy. Since the Policy insures the Policyholder and not the individuals covered by the Policyholder's health plan, the Policy neither adds to nor subtracts from the terms of the underlying Plan. Additionally, the Policy does not, in any way, affect the Policyholder's responsibility to comply with applicable employment laws such as the Americans With Disabilities Act, the Age Discrimination in Employment Act, Title VII of the 1964 Civil Rights Act, the Patient Protection and Affordable Care Act and any applicable state laws. By acceptance of this policy, the Policyholder (Employer) understands the liability assumed under the portion of the Policyholder's employee benefit plan which is self-funded and further understands that the Policyholder is exempt from Article 1.14-1 of the Texas Insurance Code (Unauthorized Insurance) only if a qualified employee benefits plan has been filed and meets the requirements of ERISA.

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

TEXAS NOTICE

IMPORTANT NOTICE

To obtain information or make a complaint, you may call Our toll-free number at:

1-800-352-4462

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
P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771
Web: http://www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES:
Should you have a dispute concerning Your premium or about a claim, You should contact Us 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.

TX NOTICE
AVISO IMPORTANTE

Para obtener informacion o para someter una queja, usted puede llamar al numero de telefano gratis de Companias al:

1-800-352-4462

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.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS SOBRE PRIMAS O RECLAMOS:
Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con la Compania 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.

Other important information

For Insurance Customers in CA, CT, GA, IL, MA, ME, MN, MT, NC, NJ, OH, OR, and VA only: Under state law, you have the right see the personal information about you that we have on file. To see your information, write ACE US Customer Services, P.O. Box 1000, 436 Walnut Street, WA04B, Philadelphia, PA 19106. ACE USA may charge a reasonable fee to cover the costs of providing this information. If you think any of the information is wrong, you may write us. We will let you know what actions we take. If you do not agree with our actions, you may send us a statement. If you want a full description of privacy rights that we will protect in accordance with the law in your home state, please contact us and we will provide it. We may disclose information to certain third parties, such as law enforcement officers, without your permission.

For Nevada residents only: We may contact our existing customers by telephone to offer additional insurance products that we believe may be of interest to you. Under state law, you have the right to opt out of these calls by adding your name to our internal do-not-call list. To opt out of these calls, or for more information about your opt out rights, please contact our customer service department. You can reach us by calling **1-800-352-4462**, emailing us at info@acegroup.com, or writing to P.O. Box 1000, 436 Walnut Street, WA04B, Philadelphia, PA 19106. You are being provided this notice under Nevada state law. In addition to contacting ACE, Nevada residents can contact the Nevada Attorney General for more information about your opt out rights by calling 775-684-1100, emailing bcpinfo@ag.state.nv.us, or by writing to: Office of the Attorney General, Nevada Department of Justice, Bureau of Consumer Protection. 100 North Carson Street, Carson City, NV 89701.

For Vermont residents only: Under state law, we will not share information about your creditworthiness within our corporate family except with your authorization or consent, but we may share information about our transactions or experiences with you within our corporate family without your consent.

ACE Group of Companies legal entities

ACE Group of Companies use the names: ACE American Insurance Company, ACE Fire Underwriters Insurance Company, ACE Insurance Company of the Midwest, ACE Property and Casualty Insurance Company, Atlantic Employers Insurance Company, Bankers Standard Fire and Marine Company, Bankers Standard Insurance Company, Century Indemnity Company, Illinois Union Insurance Company, Indemnity Insurance Company of North America, Insurance Company of North America, Pacific Employers Insurance Company, Westchester Fire Insurance Company, Westchester Surplus Lines Insurance Company, ESIS, Inc., Combined Insurance Company of America, Combined Life Insurance Company of New York, Penn Millers Insurance Company, Agri General Insurance Company

Who we are	
Who is providing this notice?	The ACE Group of Companies. A list of these companies is located at the end of this document.

What we do	
How does ACE Group protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. We restrict access to personal information to our employees, affiliates' employees, or others who need to know that information to service the account or to conduct our normal business operations.
How does ACE Group collect my personal information?	We collect your personal information, for example, when you ▪ apply for insurance or pay insurance premiums ▪ file an insurance claim or provide account information ▪ give us your contact information We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.
Why can't I limit all sharing?	Federal law gives you the right to limit only ▪ sharing for affiliates' everyday business purposes – information about your creditworthiness ▪ affiliates from using your information to market to you ▪ sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing. See below for more on your rights under state law.

Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. ▪ Our affiliates include those with an ACE name and financial companies, such as Westchester Fire Insurance Company and ESIS, Inc.
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. ▪ ACE does not share with nonaffiliates so they can market to you.
Joint Marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. ▪ Our joint marketing partners include categories of companies such as banks.

ACE GROUP OF COMPANIES
U.S. PRIVACY NOTICE

FACTS	WHAT DOES THE ACE GROUP OF COMPANIES DO WITH YOUR PERSONAL INFORMATION?
Why?	Insurance companies choose how they share your personal information. Federal and state law gives consumers the right to limit some but not all sharing. Federal and state law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: ▪ Social Security number and payment history ▪ insurance claim history and medical information ▪ account transactions and credit scores When you are no longer our customer, we continue to share information about you as described in this notice.
How?	All insurance companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons insurance companies can share their customers' personal information; the reasons the ACE Group chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does ACE share?	Can you limit this sharing?
For our everyday business purposes – such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes – to offer our products and services to you	Yes	No
For joint marketing with other financial companies	Yes	No
For our affiliates' everyday business purposes – information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes – information about your creditworthiness	No	We don't share
For our affiliates to market to you	No	We don't share
For nonaffiliates to market to you	No	We don't share

Questions?	Call 1-800-352-4462 or go to www.acegroup.com/us-en/contact-us/general-inquiry-form.aspx

September 17, 2015

Mr. Randy McGraw
HUB International Insurance Services
201 E. Main Street
Suite 800
El Paso, Texas 79998-1021

International Risk Consultants

RE: HOUSING AUTHORITY OF THE CITY OF EL PASO
JULY 1, 2015

Dear Randy:

Enclosed please find two copies of the ACE American Insurance Company Excess Loss Insurance Policy for the above named group effective July 1, 2015. Please have your client sign the Policy Acceptance Page 4, keep one copy for their files and return the entire signed original contract to our office. Please be certain that the contract returned to us contains original signatures.

Please note on Page 1 of the Policy, there is a reference to Licensed Resident Agent. This does not require a signature.

Please note that no items should be changed in this Issued Policy.

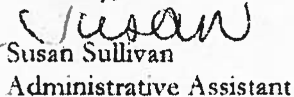
The Plan Document and amendment approved and addressed in our September 17, 2015 letter by our office become part of this Excess Loss Insurance Policy.

Please be advised that all eligible expenses under the Excess Loss Insurance Policy will be based on the legal interpretation of the Plan Document in conjunction with the Excess Loss Policy terms. Eligible expenses will be based upon Reasonable and Customary charges that meet medical necessity.

If the Plan Document in effect on the Policy effective date is subsequently amended, notice of the amendment must be given to IRC for approval prior to the proposed effective date of the change. If written notice is not received prior to the proposed effective date, eligible expenses will be based on the previously approved level of benefits.

If you should have any questions, please let us know.

Sincerely,



Susan Sullivan
Administrative Assistant

Enclosure

One Corporation Way, Suite 230, Peabody, Massachusetts 01960
Office 781-581-9800 / FAX 781-581-9888