4800 DEERWOOD CAMPUS PARKWAY,
JACKSONVILLE, FL 32246
800-477-3736

POLICY NUMBER	**BCFL1166**
POLICYHOLDER	**City of Port St. Lucie**
TYPE OF COVERAGE	Stop Loss Insurance
EFFECTIVE DATE	**October 1, 2025**
POLICY TERM	**10/01/2025 – 09/30/2026**
POLICY ISSUED IN	Florida and governed by the laws of that state.

Florida Blue agrees to pay the benefits provided by this Policy, in accordance with the provisions of this Policy.

The consideration for this Policy is the application of the Policyholder and the payment by the Policyholder of premiums as provided herein.

This Policy provides benefits to the Policyholder when Eligible Claims Expenses, which are actually Paid by the Policyholder through the Covered Underlying Plan(s), exceed the levels defined in this Policy. The benefits of this Policy and the terms and conditions that apply to this Policy are explained herein.

The Effective Date of this Policy is 12:01 AM Eastern Time on the first day of the Policy Term and the expiration date of this Policy is 11:59 PM Eastern Time on the last day of the Policy Term. This Policy may be renewed for subsequent Policy terms in accordance with the renewal terms outlined in this Policy. If this policy is renewed the terms and conditions of this Policy may be revised.

This Policy is governed by the laws of the jurisdiction in which it is issued.

All provisions on this and the following pages are a part of this Policy. Participants can contact 800-477-3736 for assistance with questions and complaints.

FLORIDA BLUE

By

Patrick J. Geraghty
Chief Executive Officer

This Policy is Non-Participating

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4.	Covered Underlying Plan(s)	
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B. SPECIFIC BENEFIT SCHEDULE

For all Eligible Claims Expenses except those to which a Special Risk Limitation applies:

1. Covered Claims Basis

   Incurred and Paid Period: Eligible Claims Expenses Incurred from 10/01/2023 through 09/30/2026 and Paid from 10/01/2025 through 09/30/2026.

2. Specific Eligible Claims Expenses include:

Medical	**[X]** Yes	**[ ]** No
Prescription Drug Card	**[X]** Yes	**[ ]** No
Prescription Drug Under Medical	**[X]** Yes	**[ ]** No
Other:	**[ ]** Yes	**[X]** No

3. Number of Covered Units

   Composite **1,320**

4. Specific Deductible

   Per Participant $**500,000**

5. Specific Payable Percentage **100**%

6. Maximum Specific Benefit

   Per Participant in excess of the Specific Deductible

   Per Policy Term Unlimited

   Per Lifetime Unlimited

C. AGGREGATE BENEFIT SCHEDULE

For all Eligible Claims Expenses except those to which a Special Risk Limitation applies:

1. Covered Claims Basis

   Incurred and Paid Period: Eligible Claims Expenses Incurred from10/01/2023 through 09/30/2026 and Paid from 10/01/2025 through 09/30/2026.

2. Aggregate Eligible Claims Expenses include:

Medical	**[X]** Yes	**[ ]** No
Dental	**[ ]** Yes	**[X]** No
Vision	**[ ]** Yes	**[X]** No
Prescription Drug Card	**[X]** Yes	**[ ]** No
Prescription Drug Under Medical	**[X]** Yes	**[ ]** No
Short Term Disability	**[ ]** Yes	**[X]** No
Other:	**[ ]** Yes	**[X]** No

3. Number of Covered Units

   Composite **1,320**

4. Aggregate Payable Percentage: **100**%

5. Aggregate Corridor **125**%

6. Minimum Aggregate Deductible $**34,453,267**

7. Annual Aggregate Deductible

   is equal to A or B whichever is greater, where:

   A = The sum of the Monthly Aggregate Deductible Amounts applicable to each Policy Month in the current Policy Term.

   B = The Minimum Aggregate Deductible.

   Note: The Annual Aggregate Deductible cannot be finally determined until the end of the Policy Term.

8. Monthly Aggregate Factor

   Composite Covered Unit per Policy Month $**2,175.08**

9. Maximum Aggregate Eligible Claims Expense

   Per Participant $**500,000**

10. Maximum Aggregate Benefit $**1,000,000**

D. PREMIUM

Specific Premium Rate per Policy Month per Covered Unit:

Composite: $**92.98**

Aggregate Premium Rate per Policy Month Per Covered Unit: $**2.99**

The Specific Premium per Month and the Aggregate Premium per Month per Covered Unit only applies to the Policy Term.

E. SPECIAL RISK LIMITATIONS:

Retirees are included in coverage.

[redacted] will have a $600,000 Specific Deductible.

Regenexx is covered under the Specific and Aggregate Stop Loss as an exception.

F. AFFILIATES

None

Part 2. DEFINITIONS

AFFILIATE means a company subsidiary to, affiliated with, or controlled by the Policyholder. Eligible Affiliates are shown in the Declaration Page. Additions and terminations may only be made by amendment to coverage under this Policy. Termination of an Affiliate is treated as termination of coverage for that company only.

AGENT, means the Policyholder's representative, including but not limited to, the agent, producer or broker of record, or Claims Administrator other than FLORIDA BLUE.

AGGREGATE BENEFIT means a benefit that is paid when Aggregate Eligible Claims Expenses Paid by the Policyholder on Covered Units in the Covered Claims Basis for the Policy Term exceed the Annual Aggregate Deductible shown in the Aggregate Benefit Schedule.

AGGREGATE Corridor means the percentage of anticipated Aggregate Eligible Claims Expenses for the covered Claims Basis for the Policy term which the Policyholder must pay before an Aggregate Benefit is paid to the Policyholder.

AGGREGATE ELIGIBLE CLAIMS EXPENSE means Eligible Claims Expenses that are Paid by the Policyholder during the Covered Claims Basis for the Policy Term used to calculate the Aggregate Benefit for that Policy Term. This term does not include any Eligible Claims Expense that exceeds the Maximum Aggregate Eligible Claim Expense that exceeds the Maximum Aggregate Eligible Claim Expense as shown in the Aggregate Benefit Schedule.

AGGREGATE PAYABLE PERCENTAGE means the percentage of the Aggregate Benefit that will be paid to the Policyholder for the Policy Term, in excess of the Annual Aggregate Deductible, as shown in the Aggregate Benefit Schedule.

ALTERNATE SPECIFIC DEDUCTIBLE means a separate Specific Deductible, if any, shown in Special Risk Limitations for certain Participants identified in the Policy which must be satisfied prior to any Specific Benefit becoming payable with respect to such Participant.

ANNUAL AGGREGATE DEDUCTIBLE means the dollar amount of Aggregate Eligible Claims Expenses that must be Paid by the Policyholder for all Covered Units during the Covered Claims Basis for the Policy Term before an Aggregate Benefit is paid to the Policyholder.

This amount cannot be finally determined until the end of the Policy Term; the calculation is based on the formula shown in the Aggregate Benefit Schedule.

APPLICATION means the written request of an entity through its duly authorized representative(s) for insurance under this Policy on a form acceptable to us.

CATASTROPHIC CLAIM means any Known claim for a Covered Service(s) Incurred or expected to be Incurred by a Participant that the Policyholder may reasonably assume will exceed 50% of the Specific Deductible in the current or next Policy Term.

CENSUS AND DEMOGRAPHIC INFORMATION means to provide the data requested by us in connection with the application for, or renewal of, this Policy on any Participant enrolled in a Covered Underlying Plan who is an active employee or member, laid off, on a leave of absence, retired, Medicare eligible, eligible for COBRA or COBRA participants, not actively at work, disabled, or confined to a hospital, and the number of Covered Units.

CLAIMS ADMINISTRATOR means the third party administrator(s) designated by the Policyholder and, if other than FLORIDA BLUE, approved by us. The Claims Administrator(s) is/are shown in the Declaration Page

CLAIM INFORMATION means to provide the data requested by us in connection with the application for, or renewal of, this Policy on any claim incurred, paid or pended on any Participant enrolled in a Covered Underlying Plan 90 days prior to the beginning of any Policy Term. Claim Information includes but is not limited to Catastrophic Claims, Large Claims and Shock Losses.

COVERED CLAIMS BASIS means the Incurred and Paid Period as shown in the Specific Benefit Schedule and the Aggregate Benefit Schedule during which an Eligible Claims Expense must be Incurred and the time period during which an Eligible Claims Expense must be Paid by the Policyholder for the Policy Term.

COVERED SERVICE or **SERVICE(S)** means a services, supplies or treatments for which the Participant has incurred an Eligible Claims Expense and for which benefits are payable through the Covered Underlying Plan(s) during Covered Claims Basis for the Policy Term. This does not include Excluded Claims Expenses or any services, supplies or treatments excluded under Special Risk Limitations.

COVERED UNDERLYING PLAN(S) means the plans which are identified in this Policy. This does not include any plan or portion of a plan, its subsidiaries or any other part of a group that has been excluded under Special Risk Limitations.

COVERED UNIT or COVERED UNITS means a group of one or more Participants composed of one or more of the following types of Covered Units:

1. Single - a single employee, associate or member; or
2. Family - an employee, associate or member and all of his or her dependents; or
3. Composite - the employee, associate or member.

Eligible for coverage under a Covered Underlying Plan.

DEDUCTIBLE(S) means the Specific Deductible, Alternative Specific Deductible, or Aggregate Deductible, as shown in the Specific Benefit Schedule, the Aggregate Benefit Schedule or the Special Risk Limitation Rider.

DISCLOSURE OR DISCLOSED means to provide Claim Information and any other documentation or data requested by us including but not limited to Census and Demographic Information and the estimated number of Participants prior to the initial Policy Term.

DOMESTIC CLAIMS mean a claim for a Covered Service received by a Participant at a facility provided by the Policyholder or an Affiliate.

EFFECTIVE DATE means the date shown on the cover page of this Policy.

ELIGIBLE CLAIMS EXPENSE means an expense for a Covered Service which is Incurred by a Participant and for which benefits have been Paid by the Policyholder during the Covered Claims Basis of the Policy. This term does not include an expense:

1. Not specifically included under the terms of the Covered Underlying Plan; or
2. Excluded under the terms of the Covered Underlying Plan; or
3. Excluded under the terms of this Policy including Excluded Claims Expenses, if any, shown in Special Risk Limitations.
4. Paid but subsequently recovered by the Policy holder from any third party.

Eligible Claims Expenses may include any applicable surcharges assessed by state and/or federal rules, laws, or regulations but do not include any additional surcharges or penalties imposed by such rules, laws or regulations.

This term does not include any Excluded Claims Expenses in Special Risk Limitations on the Declaration Page attached to this Policy.

EXCLUDED CLAIMS EXPENSES means expenses which are Incurred by a Participant for services, supplies and treatment for, or related to, the condition, or resulting complications, of an injury or sickness described in the Exclusions and Limitations and the Special Risk Limitations

FAMILY means an employee, associate or member or student of the Policyholder, and the eligible dependents of such person who are covered, or who become eligible for coverage, through a Covered Underlying Plan.

INCURRED means the date a Participant receives a service, supply or treatment for an Eligible Claims Expense during the Covered Claims Basis of the Policy Term.

INCURRED AND PAID PERIOD means the Covered Claims Basis.

KNOWN means information affecting the administration or underwriting of this Policy, which a reasonable person can assume the Policyholder or the Policyholder's Claims Administrator had actual knowledge of prior to a request for Disclosure or Claim Information or prior to a Material Change.

LARGE CLAIM, SHOCK CLAIM OR SHOCK LOSS means any loss that is reasonably likely to result in a potentially Catastrophic Claim, or any other loss due to the nature of the injury, illness or diagnosis that the Policyholder or the Policyholder's Claims Administrator, reasonably assumes will result in a significant medical expense in the current or next Policy Term.

MATERIAL CHANGE or **CHANGE** Material Changes include, but are not limited to, the following:

1. A change in:
    a. The Census and Demographic information or Claim Information Disclosed or submitted by the Policyholder upon which our assessment of risk was based; or
    b. The Covered Underlying Plan(s) benefit description, eligibility requirements, limitations or exclusions; or
    c. The Claims Administrator.
2. A change in the number of Covered Units by more than 10%
3. A bankruptcy proceeding involving the Policyholder or an Affiliate.

MAXIMUM AGGREGATE BENEFIT means the maximum dollar amount we will pay the Policyholder for the Aggregate Benefit at the end of the Covered Claims Basis for the Policy Term. The Maximum Aggregate Benefit is shown in the Aggregate Benefit Schedule.

MAXIMUM AGGREGATE ELIGIBLE CLAIMS EXPENSE means the maximum dollar amount of Eligible Claims Expenses that are Paid by the Policyholder for a Participant during the Covered Claims Basis used to calculate the Aggregate Benefit for the Policy Term. The Maximum Aggregate Claims Expense is shown in the Aggregate Benefit Schedule.

MAXIMUM SPECIFIC BENEFIT means the maximum dollar amount we will pay the Policyholder per Participant for the Specific Benefit. The Maximum Specific Benefit is shown in the Specific Benefit Schedule.

MINIMUM AGGREGATE DEDUCTIBLE means A times by B times C, where:

A = The Monthly Aggregate Factor(s) shown in the Aggregate Benefit Schedule.

B = The number of Covered Units reported by the Policyholder to the Policyholder's Claims Administrator for the first Policy Month of the Policy Term.

C = The number of months in the Policy Term.

Times: 100%

MONTHLY AGGREGATE DEDUCTIBLE AMOUNT means, for each Policy Month of the Policy Term, A multiplied by B, where:

A = The Aggregate Factor shown in the Aggregate Benefit Schedule.

B = The number of Covered Units reported by the Policyholder or the Policyholder's Claims Administrator, if other than FLORIDA BLUE, at the start of that Policy Month.

MONTHLY AGGREGATE FACTOR means the dollar amount shown in the Aggregate Benefit Schedule.

PAID means the date:

1. Eligible Claims Expenses have been processed and approved for payment by the Policyholder or the Policyholder's Claims Administrator in accordance with the Policyholder's or Claims Administrator's standard business practices; and

2. A check or draft for remuneration has been processed and issued or is otherwise delivered to the payee electronically or in person; or a credit transaction has been agreed to by the Policyholder or the Policyholder's Claims Administrator and received by the payee electronically or in person; or the Policyholder has issued definitive payment instructions to a payment clearinghouse or similar entity.

A claim will not be considered Paid until both of these conditions are satisfied. A draft or check returned to the Policyholder or Claims Administrator for any reason, or any credit transaction not honored by the payee for any reason, or any payment returned by a clearinghouse to the Policyholder or Claims Administrator for any reason will not be considered Paid.

PARTICIPANT or PARTICIPANTS means a person who is enrolled in a Covered Underlying Plan and meets all of the Covered Underlying Plan's eligibility requirements including requirements for coverage pursuant to COBRA, if applicable.

POLICY means this contract between the Policyholder and us with respect to Stop Loss Insurance.

POLICY ANNIVERSARY means each anniversary of the Effective Date of this Policy, unless changed by agreement between the Policyholder and us.

POLICY MONTH means successive intervals of time, while this Policy is in effect, determined on a monthly basis starting on the Effective Date of this Policy. Each new interval will begin on a day that corresponds to the Effective Date of the Policy. If there is no such day in any applicable month, then the last day of the month will be used.

POLICY TERM means the time period shown in the Declaration Page. For purposes of this definition:

1. An initial Policy Term is the period of time from the effective date of the policy to the date of the first Policy Anniversary.
2. A current or renewal Policy Term is the period of time either from the effective date of the Policy, or the date of the last Policy Anniversary, to the date of the next Policy Anniversary.

Each Policy Term after the initial Policy term will begin on the Policy Anniversary. The initial Policy term will begin on the Effective Date of this Policy.

POLICYHOLDER means the entity shown on the cover page of this Policy.

PREMIUM DUE DATE means the Effective Date of this Policy and the first day of each following Policy Month.

PROVIDER(S) means a person, company or facility that provides medical services, supplies or treatments that are covered under the terms of the Covered Underlying Plan, and for which the Policyholder is required to pay a benefit in accordance with the terms of the Covered Underlying Plan.

SPECIAL RISK LIMITATION means any modification of the Policy within the terms and conditions of the Policy and state law.

SPECIFIC BENEFIT means the benefit paid when Eligible Claims Expenses Paid by the Policyholder for a Participant in the Covered Claims Basis for the Policy Term exceed the Specific Deductible.

SPECIFIC DEDUCTIBLE means the amount of Eligible Claims Expenses which must be Paid by the Policyholder for a Participant during the Covered Claims Basis for the Policy Term before a Specific Benefit is paid to the Policyholder. The Specific Deductible is shown in the Specific Benefit Schedule.

SPECIFIC PAYABLE PERCENTAGE means the percentage of the Specific Benefit that will be paid to the Policyholder in excess of the Specific Deductible. The Specific Payable Percentage is shown in the Specific Benefit Schedule.

STOP LOSS INSURANCE means the coverage provided under this Policy, which provides benefits to the Policyholder when Eligible Claims Expenses which are Paid by the Policyholder through the Covered Underlying Plan(s) exceed the levels defined in this Policy.

Part 3. BENEFITS

Benefits under this Policy will only be paid by us based on Eligible Claims Expenses through the Covered Underlying Plan(s) which are Incurred and Paid within the Covered Claims Basis for the Policy Term.

A. SPECIFIC BENEFIT

Subject to the terms and conditions of this Policy, we will pay the Policyholder Specific Benefits as it becomes due following satisfaction of the Specific Deductible.

The Specific Benefit payable with respect to a Participant will equal the amount of Eligible Claims Expenses which are Incurred and Paid by the Policyholder for that Participant during the Covered Claims Basis for this Policy Term , minus (A plus B), where:

A = The Specific Deductible for the Participant.

B = Any amounts Paid for Eligible Claims Expenses Incurred by a Participant later recovered through any recovery provision of this Policy or the Covered Underlying Plan.

Multiplied by the Specific Payable Percentage.

In no event will the Specific Benefit paid by us with respect to Eligible Claims Expenses Incurred by any one Participant exceed the Maximum Specific Benefit.
The Specific Benefit does not include any amount Paid by the Policyholder for the Policy Term for Excluded Claims Expenses.

B. AGGREGATE BENEFIT

Subject to the terms and conditions of this Policy we will pay the Policyholder an Aggregate Benefit for Eligible Claims Expenses at the end of the Covered Claims Basis for the Policy Term. The Aggregate Benefit payable will equal the total amount of the Aggregate Eligible Claims Expenses which are Paid by the Policyholder for all Covered Units during the Covered Claims Basis for the Policy Term minus A plus B, where:

A = The Annual Aggregate Deductible for the Policy Term.

B Any amounts Paid for Aggregate Eligible Claims Expenses Incurred by a Participant later recovered through any recovery provision of this Policy or the Covered Underlying Plan(s).

Multiplied by the Aggregate Payable Percentage.

The Aggregate Benefit payable does not include any amount Paid by the Policyholder for Excluded Claims Expenses.

Any Aggregate Benefit paid by us for the Policy Term will not exceed the Maximum Aggregate Benefit per Policy Term.

The amount of the final Aggregate Benefit, if any, due for the Policy Term cannot be finally determined until after the end of the Covered Claims Basis for this Policy Term.

Part 4. EXCLUSIONS AND LIMITATIONS

We will not pay the Policyholder a benefit under this Policy for:

1. COVERED UNDERLYING PLAN: Any amount actually Paid by the Policyholder for an expense Incurred

   a. Incurred when the Covered Underlying Plan is not in effect; or

   b. Incurred by a person who is not a Participant as defined by the Covered Underlying Plan when the expense is Incurred; or

   c. That is not specifically covered under the terms of the Covered Underlying Plan(s),or that the Policyholder is not required to pay in accordance with the terms of the Covered Underlying Plan(s); or

   d. That is not incurred and Paid within the Covered Claims Basis as shown in the Specific and Aggregate Benefit Schedule(s)

2. NONDISCLOSURE: Any amount which is actually Paid by the Policyholder for an expense which is Incurred by a Participant if such Participant's Known Census and Demographic Information and Claim Information were not accurately Disclosed to us by the Policyholder or the Policyholder's Claims Administrator:

   a. Prior to the initial underwriting of this Policy; or

   b. Upon request prior to:

      1. renewal; or
      2. The date a Participant becomes eligible for coverage through a Covered Underlying Plan; or
      3. The date the number of Covered Units changes by more than 10%:

3 MISREPRESENTATION: Any amount which is actually Paid by the Policyholder for an expense which is Incurred by a Participant if Claim Information was requested prior to beginning of any Policy Term, and either the requested Claim Information was not provided or the Known Claim Information provided was inaccurate or incomplete in a material respect.

4. OTHER COVERAGE: The amount of any expenses for benefits to any Participant with coverage under any other plan which, when combined with the benefits payable by such other plan, would cause the total paid by that plan and the Covered Underlying Plan(s) to exceed 100% of the Participant's Eligible Claims actual expenses.

5. ADMINISTRATIVE COSTS: Any amount, incurred by the Policyholder for administrative costs, including but not limited to, such costs for:

   a. Administrative costs, including but not limited to costs for claims administration, claim payments, , PPO access fees unless satisfactory proof of loss is provided which demonstrates actual cost savings, in which case, fees actually paid to vendors by the Policyholder may be reimbursed up to 25% of savings.; or

   b. Capitation fees; or

   c. The expense of litigation; or

   d. Extra-contractual damages, compensatory damages, or punitive damages.

6. WAR: Any amount actually Paid by the Policyholder for Eligible Claims Expenses which arise out of or are caused or contributed to by war or an act of war.

   WAR means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature. This term includes acts of terrorism.

7. WORK RELATED: Any amount actually Paid by the Policyholder through the Covered Underlying Plan(s) for any injury or illness which is eligible for coverage under a workers' compensation or occupational disease policy or agreement.

8. FELONY: Any amount actually Paid by the Policyholder for Eligible Claims Expenses for any period caused or contributed to by a Participant committing or attempting to commit an assault, felony or participating in an illegal occupation, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing his or her official duties.

9. FOREIGN MEDICAL CARE: Any amount incurred by a Participant for the cost of drugs**,** procedures, services, supplies or treatments, other than drugs received from a licensed Canadian pharmacy or pharmacist, rendered or received in person, by mail or otherwise outside the United States if the purpose of such travel or communication is to obtain or receive such service, supply or treatment.

10. USUAL AND CUSTOMARY CHARGE: Any amount which is actually Paid by the Policyholder in excess of the usual and customary charge for the Covered Service, as defined and/or applied by the Covered Underlying Plan(s).

11. EXPERIMENTAL OR INVESTIGATIONAL: Any amount which is actually Paid by the Policyholder for the cost of drugs, procedures, services, supplies or treatments which are considered experimental or investigational.

12. NOT MEDICALLY NECESSARY: Any amount which is actually Paid by the Policyholder for the cost of procedures, drugs, treatments, services, or supplies which are not medically necessary and appropriate, as determined by the Food and Drug Administration, the American Medical Association, their successor organization(s), or other generally accepted medical compendia.

13. LOST PROVIDER DISCOUNTS: Provider discounts of any kind lost due to untimely payment of claims by the Policyholder, Claims Administrator or a third party vendor retained by either the Policyholder or Claims Administrator.

14. EXCESS REIMBURSEMENT: Any amount in excess of the fee, reimbursement percentage or other form of payment negotiated with a provider or facility by the Applicant, Policyholder or Designated TPA as total reimbursement to the provider or facility for the cost of drugs, procedures, services and supplies through the Covered Underlying Plan(s).

Part 5. CLAIMS ADMINISTRATOR

The Policyholder must retain a Claims Administrator at all times. We will only reimburse the Policyholder for Eligible Claims Expenses paid by an approved Claims Administrator.

All Claims Administrators must be approved by us. The Claims Administrator performs as the Policyholder's agent and we will not be held liable for any act or omission of the Claims Administrator, if other than FLORIDA BLUE.

We will only reimburse the Policyholder for Eligible Claims Expenses paid by an approved Claims Administrator.

The Policyholder must ensure that its Claims Administrator:

1. Supervises the administration and adjustment of all claims and verify the accuracy and computation of all claims in accordance with the terms of the Covered Underlying Plan;
2. Maintains accurate records of all claim payments;
3. Maintains separate records of expenses not covered; and
4. Provides us with the following data for the preceding Policy Month on or before the 30th day of each succeeding Policy Month:
    a. notice of claims that reach 50% of the Specific Deductible; and
    b. number of Covered Units; and
    c. total amount of claims paid.
5. Secures and keeps renewed, at their expense, all licenses, permits, authorizations or certificates of authority in the states where the Claims Administrator conducts the business of insurance in accordance with statutory requirements.

We will not be responsible for any compensation due to the Claims Administrator for functions performed by the Claims Administrator, for the Policyholder. This Policy will not be deemed to make us a party to any agreement between the Policyholder and the Claims Administrator.

For the purpose of any notice required from us under the provisions of this Policy, notice to the Policyholder's Claims Administrator, will be considered notice to the Policyholder and notice to the Policyholder will be considered notice to the Policyholder's Claims Administrator.

Part 6. CLAIM PROVISIONS

A NOTICE REQUIREMENT

The Policyholder or the Policyholder's Claims Administrator, must notify us when: A Participant has Incurred Eligible Claims Expenses through the Covered Underlying Plan(s) for a Catastrophic Claim, Large Claim or Shock Loss; or
A Participant has Incurred Eligible Claims Expenses through the Covered Underlying Plan(s) that exceed 50% of the Specific Deductible, or $50,000, whichever is less.

Such notification regarding Eligible Claims Expenses Incurred by a Participant must include:

1. The identity of or unique identifier associated with the Participant.
2. A description of the illness or accident and the prognosis.
3. A listing of the Eligible Claims Expenses Incurred by or Known to the Policyholder to date through the Covered Underlying Plan(s).

Failure to give notice will not invalidate or reduce any claim if it is shown not to have been reasonably possible to give such notice in time and that notice was given as soon as was reasonably possible.

B. PROOF OF LOSS

The Policyholder or the Policyholder's Claims Administrator must provide satisfactory proof of loss to support a claim within 90 days after the end of the Covered Claims Basis for the Policy Term. Claims not filed within this time limit will be denied and no benefits will be paid by us.

Upon presentation of satisfactory proof of loss the Policyholder represents that:

Monies necessary to pay for services and supplies have been paid to the Participant or respective Providers of medical services or supplies to which the claim for reimbursement under the Policy relates.

C. PAYMENT OF CLAIM

Subject to satisfactory proof of loss, any benefits payable under the Policy will be paid within 45 days immediately following our receipt of such proof of loss.

Part 7. MATERIAL CHANGES

We reserve the right to approve any Material Change or Change, including those required by applicable law. The Policyholder or the Policyholder's Claims Administrator, must notify us of any Change in writing prior to the effective date of such Change.

Upon receipt of a Material Change we reserve the right to:

1. Accept the Change without revising the Premium Rates and/or other terms and conditions of this Policy; or
2. Accept the Change and revise the Premium Rates and/or other terms and conditions of this Policy; or
3. Not accept the Change and pay benefits under this Policy as if the Change had not occurred.

If we accept the Change we will consider the Change approved on the date of the Change.

Payment of any benefits under this Policy based on a Change is subject to the Policyholder's written acceptance of any necessary adjustment to the premium.

Part 8. TERMINATION AND RENEWAL

A. TERMINATION

This Policy and all coverage under this Policy will terminate 11:59 PM Eastern Time on the earliest of the following dates:

1. The end of the last period for which premiums were paid.
2. The last day before the Premium Due Date following receipt by us of written notice from the Policyholder that this Policy is to be terminated.
3. The end of any Policy Term, following 45 days prior written notice to the Policyholder of termination.
4. The last day before the Premium Due Date following 45 days prior written notice to the Policyholder that we are planning to terminate this Policy because:
   a. there are fewer than 50 Covered Units Participants**;** or
   b. we have refused to accept a Material Change; or
   c. the Policyholder has refused to accept any necessary adjustment to the premium due to a Material Change; or
5. The date the Covered Underlying Plan(s) and all coverage under such plan(s) end.
6. The date of cancellation of the administrative agreement between the Policyholder and the Claims Administrator unless the Policyholder has selected another administrator prior to such cancellation and we have consented to the Policyholder's selection in writing.
7. On any date mutually agreed to by the Policyholder and us.

If this Policy terminates prior to the end of the Policy Term:

1. The Covered Claims Basis of this Policy will be limited to Eligible Claims Expenses Incurred and Paid by 11:59 PM Eastern Time up to the date this Policy terminates.
2. the Aggregate Benefit, if any, will not be pro-rated and the full Annual Aggregate Deductible will still apply to Eligible Claims Expenses Incurred and Paid by 11:59 PM Eastern Time on the date this Policy terminates.

B. RENEWAL

Unless terminated during or prior to the end of Policy Term, this Policy may be renewed. At that time we reserve the right to revise the terms and conditions that apply to the Policy (including but not limited to the rates, deductibles, and factors) by providing written notice to the Policyholder.

Renewal is subject to:

1. Receipt of any requested Census and Demographic Information and Claim Information prior to the beginning of the subsequent Policy Term; and
2. The Policyholder's written acceptance of the terms and conditions that apply to the renewal prior to the beginning of the subsequent Policy Term.

Part 9. PREMIUMS

A. MONTHLY PREMIUMS

The premium due each month is calculated based upon:

1. The type(s) of Covered Units shown under Number of Covered Units in the Specific Benefit Schedule and the Aggregate Benefit Schedule; and
2. The number of Covered Units reported in the Policy Month.

Any adjustments in premium due to enrollment changes should specify the enrollment adjustment for each Covered Unit by coverage type and the policy month for which the adjustment applies, and include the corresponding premium adjustment.

B. CHANGES IN PREMIUM RATES

We reserve the right to change any rate or percentage used in determining the monthly premium. The change may occur on one of the following dates:

1. On any Premium Due Date, if the number of Covered Units shown on the Declaration Page of the Policy changes by more than 10%.
2. On any Premium Due Date, if we determine that claim payments are not being made in accordance with the terms and conditions of the Covered Underlying Plan(s).
3. On the first Premium Due Date coincident with or following the date of a Material Change approved by us; or
4. On the first Premium due Date coincident with or following the date the Policyholder replaces the current Claims Administrator, provided we have consented to the change in writing.
5. On any Premium Due Date, if any other change in factors bearing on the risk assumed by us, including but not limited to the age, sex, geographic location and occupation of Participants, or a change in law or legislation changes the nature of the risk assumed under this Policy by more than 10%.
6. On any Policy Anniversary.
7. At the end of any Policy Term.

We will give the Policyholder 30 days prior written notice of any change in any rate or percentage used in determining the monthly premium.

C. PAYMENT OF PREMIUMS

All premiums are due on the applicable Premium Due Date. Each premium is payable by the Policyholder on or before the Premium Due Date direct to us at our Home Office. Except for the last month of the Policy Term the payment of each premium as it becomes due will maintain this Policy in force through the date immediately preceding the next Premium Due Date.

D. GRACE PERIOD

A Grace Period of 31 days will be allowed for the payment of each premium after the first premium. Should a premium which is otherwise due not be paid during the Grace Period, this Policy will automatically terminate on the last day of the Policy Month for which premiums were last paid at 11:59 PM Eastern Time, after written notice is given to the Policyholder. Our liability will be limited to Eligible Claims Expenses that are Incurred by the Policyholder prior to 11:59 PM Eastern Time on the last day of the Policy Month for which premiums were last paid, once the Grace Period and written notification period has expired.

Part 10. GENERAL PROVISIONS

A. HOLD HARMLESS

Both we and the Policyholder agree to hold each other harmless from any legal expenses incurred or judgments awarded arising out of any dispute involving a current or former Participant in the Policyholder's Covered Underlying Plan(s), to the extent such legal expenses or Judgments were not incurred as a result of either party’s negligence or wrongful acts.

This provision shall survive the termination of this Policy.

B. TAXES

The Policyholder agrees to hold us harmless from any state premium taxes incurred with respect to funds paid to or by the Policyholder through the Covered Underlying Plan(s). If any state premium tax is assessed against us with respect to such funds, the Policyholder must reimburse us for the amount of the state premium tax liability including any interest, penalty and costs incurred by us as a result of the assessment. Taxes incurred with respect to premiums paid for this Policy will be our responsibility.

C. ASSESSMENTS

State and federal laws may assess us based on the state of residence of Participants covered by this Policy. We reserve the right to increase premium rates to cover expected cost of any such assessment based on the number of Covered Units reported and the assessment rate in effect at the beginning of any Policy Term.

D. STATE HEALTH CARE SURCHARGES OR FEES

If you or your Claims Administrator pays a state mandated health care surcharge or fee in connection with the payment of Eligible Claim Expenses, such charge will be considered an Eligible Claim Expense.

Penalties or fines, including but not limited to late payment charges associated with such surcharge or any administrative expenses incurred in connection with such payment will not be considered an Eligible Claim Expenses.

E. NOTICE OF OBJECTION

Any objection, notice of legal action, or complaint received on a claim processed by the Policyholder or the Claims Administrator, if other than FLORIDA BLUE, and on which it reasonably appears a benefit has been or will be payable to the Policyholder under this Policy, must be brought to the immediate attention of our claims department.

F. POLICY NON-PARTICIPATING

This Policy is non-participating and does not share in our surplus earnings.

G. OFFSET

We have the right to offset any benefits payable to the Policyholder under this Policy against premiums or other payments that are due and unpaid by the Policyholder, but this right will not prevent the termination of this Policy for the non-payment of premium or failure to abide by any other term of this Policy.

H. RECOVERY

The Policyholder must prosecute any and all valid claims that the Policyholder may have against third parties arising out of any occurrence resulting in a payment for Eligible Claims Expenses by the Policyholder and must account to us for any amounts recovered.

However, if the Policyholder does not prosecute any and all valid claims that the Policyholder may have against third parties arising out of any occurrence resulting in a payment for Eligible Claims Expenses by the Policyholder within a reasonable period of time, we may, at our discretion, either subrogate the recovery of such claims on behalf of the Policyholder or require the Policyholder to assign us the right to prosecute such claims on behalf of the Policyholder.

At that time we may, at our option, bring legal action to recover from the third party the amount of any benefits we paid to the Policyholder in connection with the payment of Eligible Claims Expenses caused by the third party's negligence or wrong-doing. The Policyholder will be required to provide us with any legal instruments, documents, or a paper we may need to exercise our right to recover and the Policyholder is prohibited from doing anything to prejudice our right to recover payments from the third party.

I. REIMBURSEMENT

The Policyholder must repay us for any Eligible Claims Expenses recovered from any third party for which a benefit was paid under this Policy. This provision will survive the termination of this Policy.

J. WAIVER

Our failure to insist upon the Policyholder's or the Policyholder's Claim Administrator's strict compliance with any requirement or condition of this Policy at any time or under any circumstance will not constitute a waiver of any such requirement or condition by us at any time under the same or different circumstances.

K. ARBITRATION

In the event of a dispute between the parties to this Policy as to whether coverage is provided under this Policy for a claim made by or against the Policyholder, both parties may, by mutual consent, agree in writing to arbitration of the disagreement.

If both parties agree to arbitrate, each party will select an arbitrator. The two arbitrators will select a third arbitrator. If they cannot agree within 30 days upon a third arbitrator, both parties must request that selection of a third arbitrator be made by a judge of a court having jurisdiction.

Unless both parties agree otherwise, arbitration will take place in Florida.

Local rules of law as to procedure and evidence will apply.

A decision agreed to by any two will be binding. Each party will:

1. Pay the expenses it incurs; and
2. Bear the expenses of the third arbitrator equally.

L. RECOVERY OF OVERPAYMENT

If benefits are overpaid, we have the right to recover the amount overpaid by either of the following methods.

1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under this Policy.

Part 11. RECORDS AND REPORTS

A. REPORTING

The Policyholder or the Policyholder's Claims Administrator, must:

1. Keep appropriate records regarding administration of the Covered Underlying Plans; and
2. Allow us to review and copy, during normal business hours, all records affecting our liability under this Policy; and
3. Submit all proofs, reports, and supporting documents requested by us, including, but not limited to, a monthly summary of all Eligible Claims Expenses which were processed by the Policyholder or the Policyholder's Claims Administrator, on a timely basis.

B. Clerical error, whether by the Policyholder the Policyholder's Claims Administrator, or by us, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

C. AUDITS

We reserve the right to inspect and audit all of the Policyholder's and the Policyholder's Claims Administrator's records and procedures that pertain to this Policy. We also reserve the right to require proof that payment of Eligible Claims Expenses has been made to the Participant or the

provider of the Covered Services that are the basis for any claim by the Policyholder under this Policy.

This provision shall survive the termination of this Policy.

D. UNDERWRITING INFORMATION

We rely on the (including but not limited to Census and Demographic Information and Claim Information) provided by the Policyholder or the Policyholder's Claims Administrator:

1. To issue this Policy; and
2. To accept a person as a Participant; and
3. To renew this Policy.

Should additional information become Known that affects the terms and conditions of this Policy (including but not limited to the rates, deductibles, corridor and factors), we reserve the right to revise the terms and conditions of this Policy on any Premium Due Date by providing written notice to the Policyholder.

Part 12. LIABILITY

LIABILITY

We will have neither the right nor the obligation under this Policy to directly pay any Participant or provider of Covered Services for any benefit that the Policyholder has agreed to provide through the terms of the Covered Underlying Plan(s). Our sole liability under this Policy is to the Policyholder.

Part 13. INDEMNIFICATION

INDEMNIFICATION

To the extent either we or the Policyholder suffers any liability, loss or expense due to a breach of this Policy by either party or due to the other party's negligence or wrongful acts, each party agrees to indemnify the other up to the amount of such liability, loss or expense, and all costs associated with such liability, loss or expense.

Part 14. ENTIRE CONTRACT, CHANGES

The entire contract consists of:

1. The pages of this Policy including any amendments, endorsements or riders; and
2. The Application; and
3. Submitted Claim Information; and
4. Disclosure Statements and/or Disclosure Forms; and
5. Attached documents necessary for the administration of this Policy.

No change in this Policy will be valid unless it is approved in writing by one of our executive officers and delivered to the Policyholder for attachment to this Policy. This approval must be shown on or attached to this Policy. No Agent or Claims Administrator, other than FLORIDA BLUE, has authority to change this Policy or to waive any of its provisions.

Part 15. INCONTESTABLE CLAUSE

In the absence of fraud, any statement made by the Policyholder is a representation and not a warranty. No statement made by the Policyholder affecting this Policy will be used to deny a claim or to deny the validity of this Policy unless contained in a written instrument signed by the Policyholder and a copy of the written instrument has been given to the Policyholder.

Part 16. LEGAL ACTIONS

No action at law or in equity may be brought to recover under this Policy until 60 days after satisfactory proof of loss has been furnished to us. No such action may be brought more than five years after the time within which proof of loss is required to be furnished.

Part 17. INSOLVENCY

The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder or the Policyholder's Claims Administrator, other than FLORIDA BLUE, will not impose upon us any liability other than the liability defined in this Policy.

Part 18. ASSIGNMENT

The Policyholder’s rights and benefits under this Policy cannot be assigned to any person or entity, including but not limited to any Participant, medical provider, or creditor.

The rights of this Policy may be assigned under certain circumstances. No assignment of interest under this Policy will be binding upon us unless and until the original or a duplicate is on file with us. We do not assume any responsibility for the validity of an assignment.

FLORIDA BLUE
4800 DEERWOOD CAMPUS PARKWAY; JACKSONVILLE, FL 32246

SPECIFIC ADVANCE FUNDING RIDER

To be attached to and made part of Policy Number BCFL1166 issued to City of Port St. Lucie as Policyholder. To present inquiries, or to obtain information about coverage, or if assistance is needed in resolving a complaint, please call Florida Blue Customer Service at 800-477-3736 ext. 51723

Effective 10/01/2025 it is hereby agreed:

The only Covered Expenses eligible for Specific Advance Funding are those that exceed the sum of the Specific Deductible per Participant**,** or the Alternate Specific Deductible shown in the Special Risk Limitation Rider per Participant.

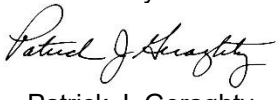
Specific Advance Funding is available if all of the following conditions have been met:

1. The Specific Deductible per Participant, or the Alternate Specific Deductible per Participant has been met.
2. Claims submitted for an advance must be fully processed by the Claims Administrator, and ready for payment according to the terms of the Benefit Plan within the current Policy Term.
3. Each request for an advance must be equal to or greater than $1,000.
4. Claims must be Incurred during the current Policy Term and we must receive the request for an advance no later than 30 standard days after the end of the current Policy Term. Any request received after this period is not eligible for Advance Specific Funding.
5. The Covered Expense for which funds were advanced must be actually Paid within five working days after receiving the advance for such expense. We will consider any Covered Expense actually Paid within this time period to have been Paid within the current Policy Term, even if such payment occurs after the end of the current Policy Term, or Run-out Period shown in the Specific Benefit Schedule, if later. If the Policyholder does not pay the Covered Expense within this time period, the advance must be refunded to us.
6. Any funds advanced by us not used to pay a Covered Expense due to any type of discounting must be refunded to us within ten working days.
7. Premiums must be paid prior to the end of the Grace Period and the policy will stay in force during that Period. However, should a premium which is otherwise due not be paid by the end of the Grace Period:
   a. The Policyholder will be given at least 10 days written notice and the Policy will automatically terminate on the last day of the Policy Month for which premiums were last paid once the Grace Period and written notification period has expired; and
   b. The Policyholder must reimburse us for any funds advanced by us during the Grace Period within five working days. Once the Grace Period and written notification period has expired.

All other terms and provisions of the Policy will continue to apply.

FLORIDA BLUE

By



Patrick J. Geraghty

Chairman of the Board and Chief Executive Officer