BlueCross BlueShield
of Texas

APPLICATION FOR STOP LOSS COVERAGE

Employer Group Name: Hidalgo Coutny
Employer Group Address: 2802 South Highway 281
City: Edinburg **State of Situs:** TX **Zip Code:** 78539
Account Number: 021185
Employer Group Number(s): 021185
Effective Date of Policy 01/01/2012
Policy Period: These specifications are for the Policy Period commencing on 01/01/2012 and ending on 12/31/2012

The specifications below shall become effective on the first day of the Policy Period specified above and shall continue in full force and effect until the earliest of the following dates: (1) The last day of the Policy Period; (2) The date the Policy terminates; or (3) The date this Application for Stop Loss Coverage (herein called the "Application") is superseded in whole or in part by a later executed Application.

A. Aggregate Stop Loss Insurance: ☐ Yes ☒ No
If yes, complete items 1 through 9 below.

1. ☐ New Coverage ☐ Renewal of Existing Coverage
2. Stop Loss Coverage Period:

☐ New Coverage (Select one from below):

☐ Standard: Claims incurred and paid during the Policy Period.

☐ "Run-in" included: Claims incurred on or after _____ and paid during the Policy Period.

"Run-in" includes claims paid by Policyholder's prior claim administrator: Yes ☐ No ☐
If yes, such claims must be reported by the Policyholder to the Company (Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) within 12 months of the Policy Effective Date and paid by the Policyholder's prior claim administrator within 6 months after the Policy Effective Date.

☐ Renewal of Existing Coverage:

Claims incurred on or after the original Effective Date of Policy and paid during the Policy Period.

3. Aggregate Stop Loss Insurance shall apply to:

☐ Medical Claims

☐ Outpatient Prescription Drug Claims

☐ Dental Claims

☐ Other (please specify): _____

4. Average Claim Value: _____ per Employee

   Attachment Factor: _____% of the Average Claim Value

5. Aggregate Claim Liability and Run-Off Claim Liability Factors

   a. Employer's Claim Liability for each Policy Period shall be the sum of the Monthly amounts obtained by multiplying the number of Coverage Units for each Month by the following factors:

      $_____ for each Employee Coverage Unit

      $_____ for each Employee/Family Coverage Unit

      Please use the continuous text field directly below for any other structure (leaving the fields above blank). Note: you can use the "return" key to create additional rows, if needed:

      _____

   b. Employer's Run-Off Claim Liability shall be calculated by multiplying the sum average of all Coverage Units during each of the three calendar Months immediately preceding termination by the factors shown below. Settlement for the final accounting period will be described in the section of the Policy entitled SETTLEMENTS, Run-Off Period subsection of the Policy.

      $_____ for each Employee Coverage Unit

      $_____ for each Employee/Family Coverage Unit

      Please use the continuous text field directly below for any other structure (leaving the fields above blank). Note: you can use the "return" key to create additional rows, if needed:

      _____

6. CAP Arrangement ☐ Yes ☐ No

7. Aggregate Stop Loss Claims

   a. The amount of Paid Claims during the current Policy Period, less:

      i. Individual (Specific) Stop Loss Claims

      ii. Any claims in excess of the Individual (Specific) Stop Loss Claims per Covered Person per Lifetime Maximum

      iii. Any claims in excess of the Individual (Specific) Stop Loss Claims maximum Point of Attachment

      that exceeds the Aggregate Point of Attachment. The Aggregate Point of Attachment shall equal the sum of the Employer's Claim Liability amounts calculated Monthly as described in Item 5.a. above for the indicated Policy Period.

   b. In the event of termination at the end of a Policy Period, the Final Settlement Aggregate Point of Attachment shall equal the sum of the Employer's Claim Liability amount for the Final Policy Period and the Employer's Run-Off Claim Liability calculated as described in item 5.b. above. However, for the indicated Policy Period the minimum Aggregate Point of Attachment shall be $_____.

   c. Aggregate Stop Loss Claims shall not exceed a lifetime maximum of _____ for the indicated Policy Period.

8. Premium (Select one):

☐ Annual Premium (Due on the first day of the Policy Period): $_____.

☐ Monthly Premium shall be equal to the amounts obtained by multiplying the number of Coverage Units for a particular Month by

$_____ for each Employee Coverage Unit

$_____ for each Employee/Family Coverage Unit

Please use the continuous text field directly below for any other structure (leaving the fields above blank). Note: you can use the "return" key to create additional rows, if needed:

_____

9. The premium is based upon a current membership of _____ Individual Coverage Units and _____ Family Coverage Units.

B. Individual (Specific) Stop Loss Insurance: ☒ Yes ☐ No

If yes, complete items 1 through 6 below.

1. ☐ New Coverage ☒ Renewal of Existing Coverage
2. Stop Loss Coverage Period:

   ☐ New Coverage (Select one from below):

   ☐ Standard: Claims incurred and paid during the Policy Period.

   ☐ "Run-in" included: Claims incurred on or after and paid during the Policy Period

   "Run-in" includes claims paid by Policyholder's prior claim administrator: Yes ☐ No ☐

   If yes, such claims must be reported by the Policyholder to the Company (Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) within months of the Policy Effective Date and paid by the Policyholder's prior claim administrator within months after the Policy Effective Date.

   ☒ Renewal of Existing Coverage:

   Claims incurred on or after the original Effective Date of Policy and paid during the Policy Period.

3. Individual (Specific) Stop Loss Insurance shall apply to:

   ☒ Medical Claims

   ☒ Outpatient Prescription Drug Claims

   ☐ Dental Claims

   ☐ Vision Claims

   ☐ Other (please specify): _____

4. Individual (Specific) Stop Loss Claims

   a. For N/A who is identified by the health identification (ID) number N/A, the amount of Paid Claims during the current Policy Period in excess of the Individual Point of Attachment of $N/A. Such amount shall apply for the Policy Period.

   b. For each other Covered Person:
   The amount of Paid Claims during the current Policy Period in excess of the Individual Point of Attachment of $170,000 per Covered Person but not to exceed a maximum Point of Attachment of $ unlimited per Policy Period. Paid Claims in excess of the maximum point of attachment shall not be eligible to satisfy the Aggregate Point of Attachment. Such amount shall apply for the Policy Period.

c. Covered Person per Lifetime Maximum:

The Individual (Specific) Stop Loss Claims shall not exceed _____ per Covered Person per Lifetime. Paid Claims in excess of the Covered Person per Lifetime Maximum shall not be eligible to satisfy the Aggregate Point of Attachment.

Point of Attachment ☒ Includes Claim Administrator's Provider Access Fee
☐ Excludes Claim Administrator's Provider Access Fee

5. Premium (select one):

☐ Annual Premium (Due on the first day of the Policy Period): $_____.

☒ Monthly Premium shall be equal to the amounts obtained by multiplying the number of Coverage Units for a particular Month by

$30.09 for each Employee Coverage Unit

$30.09 for each Employee/Family Coverage Unit

Please use the continuous text field directly below for any other structure (leaving the fields above blank). Note: you can use the "return" key to create additional rows, if needed:

_____

6. The premium is based upon a current membership of 2,575 Individual Coverage Units and 1,180 Family Coverage Units.

Additional Provisions:

_____

The undersigned person represents that he/she is authorized and responsible for purchasing stop loss coverage on behalf of the Employer Group. It is understood that the actual terms and conditions of coverage are those contained in this Application the Stop Loss Coverage Policy into which this Application shall be incorporated at the time of acceptance by Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC"). Upon acceptance, HCSC shall issue a Stop Loss Coverage Policy to the Employer Group. Upon acceptance of this Application and issuance of the Stop Loss Coverage Policy, the Employer Group shall be referred to as the "Policyholder."

Tita Iruegas
Sales Representative

Signature of Authorized Purchaser

Lynn Mori
Name of Underwriter

Title of Authorized Purchaser

Date

INTERNAL USE ONLY	Date Application approved by Underwriting:

Renewal Addendum to Benefit Program Application ("ASO BPA") Applicable to Administrative Services Only (ASO) Group Accounts

administered by Blue Cross and Blue Shield of Texas, a division of Health Care Service Corporation, a Mutual Legal Reserve Company, hereinafter referred to as "Claim Administrator" or "HCSC"

Employer Account Number (6-digits): 021185
Employer Group Number(s): 021185
Section Number(s): ALL
Employer Name: Hidalgo County
Renewal Addendum Effective Date: 01/01/2012
ERISA Plan: **Yes** ☐ **No** ☒ **If Yes, ERISA Plan Year:** N/A

THIS ADDENDUM is incorporated into and made a part of the ASO Benefit Program Application ("ASO BPA") last entered into between the parties as of this Renewal Addendum's Effective Date and the corresponding Administrative Services Agreement ("Agreement"), currently in effect between the parties. This Addendum is intended to renew the foregoing as of the abovenoted Renewal Addendum Effective Date of Coverage and, except as modified and amended and/or re-attested herein pursuant to this renewal, the provisions, conditions and terms of such ASO BPA and Agreement shall remain in full force and effect.

FEE SCHEDULE PERIOD:	☒ **No Changes**	☐ **See Additional Provisions**
To begin on Renewal Addendum Effective Date and continue for:		
☒ **12 Months** ☐ **Other (please specify):**	**Months**	

ADMINISTRATIVE CHARGE(S):	☐ **No Changes**	☐ **See Additional Provisions**		
Product / Service	**PPO**			
Base Administrative Charge (Medical)	**$36.86**	**$**	**$**	**$**
Prescription Drug Administrative Charge	**$**	**$**	**$**	**$**
Prescription Drug Rebate Credit per Covered employee per month is the guaranteed Prescription Drug Rebate savings reflected as a Prescription Drug Rebate credit. Expected rebate amounts to be received by the Claim Administrator are passed back to the Employer with one hundred percent (100%) of the expected amount applied as a credit on the monthly billing statement on a per Covered Employee per month basis. Rebate credits are paid prospectively to the Employer and shall not continue after termination of the Prescription Drug Program. (Further information concerning this credit is included in the governing Administrative Services Agreement and ASO BPA to which this Addendum is attached under the section titled "CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS.")	**$-5.81**	**$**	**$**	**$**
Blue Care Connection® ("BCC") Program: Select from Pull Down	**$**	**$**	**$**	**$**
BCC Program Upgrade(s): Description:	**$**	**$**	**$**	**$**
Description:	**$**	**$**	**$**	**$**
Special Beginnings	**$**	**$**	**$**	**$**
Other: _____	**$**	**$**	**$**	**$**
Other: _____	**$**	**$**	**$**	**$**
Dental: _____	**$**	**$**	**$**	**$**
Total	**$31.05**	**$**	**$**	**$**
NOTE: Additional services and/or fees may be itemized in the "Other" fields above or in the Additional Provisions section on page 2.				

PAYMENT SPECIFICATIONS:		☒ No Changes	☐ See Additional Provisions
Employer Payment Method:	☐ Online Bill Pay	☒ Electronic	☐ Check
Employer Payment Period:	☒ Weekly *(cannot be selected if Check is selected as payment method above)*		
☐ Twice-Monthly	☐ Monthly	☐ Other (please specify):	
Claim Settlement Period:	☒ Monthly	☐ Other (please specify):	
Run-Off Period: Employer Payments are to be made for 12 months following end of Fee Schedule Period.			
Final Settlement: Final Settlement is to be made within 60 days after end of Run-Off Period.			

TERMINATION ADMINISTRATIVE CHARGE:		☐ No Changes	☐ See Additional Provisions	
Service				
Medical Run-Off Administrative Charge	**$13.84**	**$**	**$**	**$**
Dental Run-Off Administrative Charge	**$**	**$**	**$**	**$**
Other: _____	**$**	**$**	**$**	**$**
Other: _____	**$**	**$**	**$**	**$**

ADDITIONAL PROVISIONS:

Employer acknowledges and agrees that unless a change is indicated on this Renewal Addendum, Employer's instructions, acknowledgements and agreements in the ASO BPA and the Agreement (both as defined above) shall remain in full force and effect.

Tita Iruegas

Authorized BCBSTX Representative

AE 10.21.11

Title Date

956-581-5615

BCBSTX Telephone and Fax numbers

Robert Ramirez / Alberto Trevino

Agent Representative *(if applicable)*

Date

956-783-1137 / 956-781-7771

Agent Phone & Fax Numbers

rr@puroasseguro.com / Ocarrasco03@aol.com

Agent Email Address

455689870 /454785551

Tax I.D. No.

Signature of Authorized Purchaser

Title

Date

BlueCross BlueShield
of Texas

Grandfathered Status Certification

If a group health plan (including a benefit package under a group health plan) or group health insurance coverage (each a "plan") was in effect on March 23, 2010, it may be a "grandfathered health plan" as that term is defined in the Affordable Care Act, and related regulations (currently the Interim Final Rule at 75 Fed. Reg. 34538). We are writing to provide you with information and to confirm your plan(s) status for your upcoming renewal.

The following changes or events will cause a plan to ***lose*** grandfathered health plan status:

1. If the principal purpose of a merger, acquisition or similar business restructuring is to cover new individuals under a grandfathered health plan, a plan will cease to be a grandfathered health plan.
2. A plan will cease to be a grandfathered health plan if: (i) employees are transferred into the plan (transferee plan) from another plan or group health insurance policy which the employees were covered on March 23, 2010 (transferor plan); (ii) there is no bona fide employment-based reason for transferring the employees into the transferee plan; and (iii) comparing the terms of the transferee plan with those of the transferor plan (as in effect on March 23, 2010) and treating the transferee plan as if it were an amendment of the transferor plan would cause a loss of grandfathered health plan status under the provisions of paragraph (g)(1) of the Interim Final Rule. Changing the terms or cost of coverage is not considered a bona fide employment-based reason.
3. A plan will cease to be a grandfathered health plan if the employer or employee organization decreases its contribution rate based on the cost of coverage toward the cost of any tier of coverage for any class of similarly situated individuals (as defined in the applicable regulations by more than 5 percentage points below the contribution rate for the coverage period that includes March 23, 2010. The contribution rate based on the cost of coverage means the amount of contributions made by an employer or employee organization compared to the total cost of coverage, expressed as a percentage. For determining the total cost of coverage, see the Interim Final Rule.
4. A plan will cease to be a grandfathered health plan if the employer or employee organization decreases its contribution rate based on a formula toward the cost of any tier of coverage for any class of similarly situated individuals (as defined in the applicable regulations) by more than 5 percent points below the contribution rate for the coverage period that includes March 23, 2010. For plans that on March 23, 2010, made contributions based on a formula (e.g., hours worked or salary tiers), the contribution rate based on a formula means the formula.
5. Any of the following changes will cause a plan to cease to be a grandfathered health plan:
   a) The elimination of all or substantially all benefits to diagnose or treat a particular condition or the elimination of benefits for any necessary element to diagnose or treat a condition.
   b) Any increase in a percentage cost-sharing requirement (e.g., individual's coinsurance).
   c) Any increase in a fixed-amount copayment, if the total increase in the copayment exceeds the greater of: (i) $5 increased by medical inflation measured from March 23, 2010; or (ii) the "maximum percentage increase" (the increase in the overall medical care component of the Consumer Price Index for All Urban Consumers [CPI-U] plus 15 percentage points), measured from March 23, 2010.
   d) Any increase in a fixed-amount cost-sharing requirement, other than a copayment (e.g., a deductible or out-of-pocket limit), if the total percentage increase the cost-sharing requirement exceeds the "maximum percentage increase" (the increase in the overall medical care component of the Consumer Price Index for all Urban Consumers [CPI-U] plus 15 percentage points), measured from March 23, 2010.
   e) A plan that, as of March 23, 2010, did not impose an overall annual or lifetime limit on the dollar value of all benefits imposes an overall annual limit on the dollar value of benefits.
   f) A plan that, as of March 23, 2010, imposed an overall lifetime limit on the dollar value of all benefits, but not an overall annual limit on the dollar value of all benefits, adopts an overall annual dollar limit that is lower than the dollar value of the lifetime limit in effect on March 23, 2010.
   g) A plan that, as of March 23, 2010, imposed an overall annual limit on the dollar value of all benefits decreases the dollar value on the annual limit (regardless of whether the plan also imposed an overall lifetime limit on the dollar value of all benefits as of March 23, 2010).
   h) A plan that, as of March 23, 2010, has had other changes or events that cause the plan to cease to be a grandfathered health plan as defined by the Affordable Care Act and the related regulations.

YOU ONLY NEED TO RETURN THE CERTIFICATION FORM IF YOU INTEND FOR YOUR BENEFIT (MEDICAL) PLAN(S) TO BE CONSIDERED GRANDFATHERED AS OF YOUR RENEWAL DATE.

NOTE: Grandfathered health plan status cannot be retroactively applied, so it is important that you complete, sign and return the Grandfathered Status Certification Form for your medical benefit plan(s) 30 calendar days prior to your renewal date.

Beginning on the renewal date, your Group medical benefit plan(s) will be considered NON-GRANDFATHERED.	For Your Plan(s) To Be Considered ► GRANDFATHERED ►	You MUST complete, sign and return the attached Grandfathered Status Certification Form for your medical benefit plan(s) 30 calendar days prior to your renewal date.

A Grandfathered Status Certification Worksheet is attached for your convenience.

Helpful Tips:

1) **Grandfathered Status Certification Worksheet:** For each medical benefit plan, you may wish to complete the enclosed Worksheet to help you determine if your plan(s) may qualify as a grandfathered health plan(s).

2) **Grandfathered Status Certification Form**: Please complete, sign and return this Form to your BCBS Account Representative or broker (if applicable) at least 30 calendar days **prior to your renewal date**. If the Form is not returned within at least 30 calendar days prior to renewal, then as of your renewal date your plan(s) will be considered a non-grandfathered health plan(s). Once your plan's status is changed to "non-grandfathered", the status cannot later revert back to "grandfathered" status.

BlueCross BlueShield
of Texas

Grandfathered Status Certification Worksheet

This Worksheet may assist you in determining whether your medical benefit plan(s) may qualify as grandfathered health plan(s) as defined in the Affordable Care Act and related regulations.

Notice: The grandfathered health plan provisions of the Affordable Care Act and related regulations are fact-specific. Therefore, this Worksheet is not intended as and does not serve as a means to definitely determine whether a plan is or will remain a grandfathered health plan. We recommend that you seek the advice and guidance of your legal counsel regarding the use of this Worksheet, before completing and signing the Grandfathered Status Certification Form, and regarding whether your plan(s) are grandfathered health plan(s) as defined in the Affordable Care Act and related regulations.

If you answer "Yes" to ANY of the following questions for a particular medical benefit plan, the plan may not be a grandfathered health plan.

Question	Answer
Contribution Rate/Cost of Coverage Change: Since March 23, 2010, has there been or is there intended to be a contribution rate change that would cause the plan to cease to be a grandfathered health plan as described in #3 above?	☐ Yes ☐ No
Contribution Rate/Formula Change: Since March 23, 2010, has there been or is there intended to be a contribution rate change that would cause the plan to cease to be a grandfathered health plan as described in #4 above?	☐ Yes ☐ No
Benefit and Other Changes: Since March 23, 2010, has there been or is there intended to be any benefit or other change that would cause the plan to cease to be a grandfathered health plan as described in #5a-h above?	☐ Yes ☐ No
Employee Transfers: Since March 23, 2010, has there been or is there intended to be a transfer of employees into the plan that would cause the plan to cease to be a grandfathered health plan as described in #2 above?	☐ Yes ☐ No
Merger, Acquisition, Business Restructuring: Since March 23, 2010, has there been or is there intended to be a merger, acquisition or similar business restructuring that would cause the plan to cease to be a grandfathered health plan as described in #1 above?	☐ Yes ☐ No

Transition Period: If you made changes to the terms of the plan between 3/23/2010 and 6/14/2010 the plan may maintain grandfathered status if the changes are revoked or modified effective as of the first day of the first plan year on or after 9/23/2010 and the terms of the plan on that date, as modified, would not cause the loss of grandfathered status as defined in the Affordable Care Act and related regulations.

Fully-Insured Collectively Bargained Plans: In the case of health insurance coverage maintained pursuant to one or more collective bargaining agreements ("CBAs") between employee representatives and one or more employers that was ratified before March 23, 2010, the coverage is grandfathered health plan coverage at least until the date on which the last of the CBAs relating to the coverage that was in effect on March 23, 2010 terminates. After the date on which the last of the CBAs relating to the coverage in effect on March 23, 2010 terminates, the determination of whether the coverage is grandfathered health plan coverage is made in accordance with the Interim Final Rule.

If you have questions regarding this Worksheet and grandfathered health plan status, please contact your insurance broker (if applicable), your BCBS Account Representative or your legal counsel for more information. If a plan or policy has lost or will lose grandfathered status, please contact your insurance broker (if applicable) or BCBS Representative immediately for available benefit plan options.

BlueCross BlueShield
of Texas

Grandfathered Status Certification Form

You must complete, sign and return this Form to your Account Representative or broker (if applicable) at least 30 days prior to your renewal date. If this Form is not returned within 30 days prior to your renewal date, then as of your renewal date your plan(s) will be treated as non-grandfathered health plan(s) under the Affordable Care Act and related regulations.

Group Name: Hidalgo County **Renewal Date:** 01-01-2012

Account Number: 021185

Grandfathered Status

Please complete the following information and indicate whether your existing plan(s) are (i) grandfathered health plan(s) as defined by the Affordable Care Act and related regulations, and (ii) subject to collective bargaining agreements, by checking the appropriate boxes:

Group Number	Benefit Plan Name	Benefit Plan Number	Grandfathered	Collective Bargaining Agreement
021185	PPO Plan 1	0001	☐ Yes ☐ No	☐ Yes ☐ No If yes, termination date:
021185	PPO Plan 2	0002	☐ Yes ☐ No	☐ Yes ☐ No If yes, termination date:

Add additional details on Page 5 as needed; make sure you return the table and the signature pages if they become separated.

TO BE SIGNED BY THE GROUP REPRESENTATIVE:

I, the undersigned, hereby certify and represent that I have read and understand this Grandfathered Status Certification Form and that the information contained in this Form is true and complete.

I, also agree that I will immediately provide BCBS with written notice of any changes or events that may cause any medical benefit plan(s) to cease to be grandfathered health plan(s) as defined by the Affordable Care Act and related regulations.

_______________________ Signature

_______________________ Title

_______________________ Print Name

_______________________ Date

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

BlueCross BlueShield
of Texas

Group Name **Account Number** **Date**

Group Number	Benefit Plan Name	Benefit Plan Number	Grandfathered	Collective Bargaining Agreement
			☐ Yes ☐ No	☐ Yes ☐ No If yes, termination date: ____/____/____
			☐ Yes ☐ No	☐ Yes ☐ No If yes, termination date: ____/____/____
			☐ Yes ☐ No	☐ Yes ☐ No If yes, termination date: ____/____/____
			☐ Yes ☐ No	☐ Yes ☐ No If yes, termination date: ____/____/____
			☐ Yes ☐ No	☐ Yes ☐ No If yes, termination date: ____/____/____
			☐ Yes ☐ No	☐ Yes ☐ No If yes, termination date: ____/____/____
			☐ Yes ☐ No	☐ Yes ☐ No If yes, termination date: ____/____/____
			☐ Yes ☐ No	☐ Yes ☐ No If yes, termination date: ____/____/____
			☐ Yes ☐ No	☐ Yes ☐ No If yes, termination date: ____/____/____
			☐ Yes ☐ No	☐ Yes ☐ No If yes, termination date: ____/____/____
			☐ Yes ☐ No	☐ Yes ☐ No If yes, termination date: ____/____/____
			☐ Yes ☐ No	☐ Yes ☐ No If yes, termination date: ____/____/____
			☐ Yes ☐ No	☐ Yes ☐ No If yes, termination date: ____/____/____
			☐ Yes ☐ No	☐ Yes ☐ No If yes, termination date: ____/____/____
			☐ Yes ☐ No	☐ Yes ☐ No If yes, termination date: ____/____/____
			☐ Yes ☐ No	☐ Yes ☐ No If yes, termination date: ____/____/____