



APPLICATION FOR STOP LOSS COVERAGE

Employer Group Name: Hidalgo County
Employer Group Address: 2818 South hwy 281
City: Edinburg **State of Situs:** TX **Zip Code:** 78539
Account Number: 021185
Employer Group Number(s): 021185
Effective Date of Policy: 01/01/2008

Policy Period: These specifications are for the Policy Period commencing on 01/01/2013 and ending on 12/31/2013

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the Policy terminates; or (3) The date this Application for Stop Loss Coverage (herein called the "Application") is superseded in whole or in part by a later executed Application.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 Unlimited 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 2515 Individual Coverage Units and 1223 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

County Judge
Title of Authorized Purchaser

Date

INTERNAL USE ONLY	Date Application approved by Underwriting:
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Group Term Life and Accidental Death and Dismemberment (AD&D) Benefit Highlights for Hidalgo County

Eligibility: All active full-time employees working a minimum of 25 hours per week and all county elected officials.

Basic Life and AD&D Benefit: \$25,000.

Premium: Your employer pays 100% of the premium for the Basic benefit.

Life insurance includes the following benefits:

- **Conversion Privilege:** You may convert your life insurance to an individual whole life policy if coverage terminates (due to termination of employment).
- **Portability:** You may continue your life insurance to age 65 without evidence of insurability if coverage terminates (due to termination of employment).
- **Accelerated Death Benefit:** Pays a portion of the death benefit as a living benefit up to 75% of the basic benefit in the event of a terminal illness.
- **Waiver of Premium:** If you are unable to engage in any occupation as a result of injury or sickness for a minimum of 9 months, prior to age 60, premium will be waived until you are no longer disabled or reach age 65.

AD&D insurance includes the following benefits:

- **Seat Belt:** 10% of coverage amount to a maximum of \$2,500
- **Air Bag:** 5% of coverage amount to a maximum of \$500
- **Repatriation:** Actual costs to a maximum of \$5,000
- **Education:** 3% of coverage amount to a maximum of \$3,000 per year for a maximum of 4 years
- **Public Conveyance:** Coverage amount to a maximum of \$150,000
- **Felonious Assault:** Coverage amount to a maximum of \$25,000
- **Coma:** 1% of coverage amount to a maximum of \$25,000

AD&D Limitations:

 Benefits are not payable for any loss that, directly or indirectly, results from or is contributed to by:

- suicide, attempted suicide or intentionally self-inflicted injuries while sane or insane;
- declared or undeclared war;
- accident resulting during the commission of, participation in or attempt to commit an assault or felony;
- disease, bodily or mental infirmity, or medical or surgical treatment thereof or any infection, except a pus-forming infection;
- travel or flight in an aircraft while a member of the crew, while engaged in the operation of the aircraft or while giving or receiving training or instruction in such aircraft;
- loss resulting from your being intoxicated by reason of alcohol or drug use or a combination thereof; or
- active participation in a riot.

Please note: This information is only a product highlight. Products underwritten and services provided by Fort Dearborn Life Insurance Company® (Downers Grove, IL) in all states (excluding New York), the District of Columbia, the United States Virgin Islands, the British Virgin Islands, Puerto Rico and Guam are marketed under the Dearborn National® brand and the star logo. The policy has exclusions, limitations, and reduction of benefits and/or terms under which the policy may be continued or discontinued. The policy may be cancelled by the insurer at any time. The insurer reserves the right to change premium rates, but not more than once in a 12-month period.

FORT DEARBORN LIFE
Insurance Company®

Administrative Office:
1020 31st Street
Downers Grove IL 60515-5591

(A stock life insurance company, herein called the "We" "Us" or "Our")

Policyholder: HIDALGO COUNTY
Policy Number: F019016-0001
Policy Effective Date: February 1, 2011
Anniversary Date: February 1

We agree with the *Policyholder* to insure certain eligible Employees of the *Policyholder*. We promise to pay benefits for loss covered by the Policy in accordance with its provisions. The *Policyholder* should read this Policy carefully and contact Fort Dearborn Life Insurance Company® promptly with any questions.

Policyholder means the *Employer* to whom the Policy is issued and who sponsored the coverage for its Employees.

Employer means the *Policyholder* and includes any division, subsidiary, or affiliated company named in the Policy.

POLICY EFFECTIVE DATE AND TERM

The Policy takes effect on the Policy Effective Date stated above subject to any participation requirement stated in the Policy. All insurance periods will be computed from that date. The Policy remains in force for the period for which premium has been paid. It may be renewed for further successive periods by payment of premium as stated in the Policy.

All periods of insurance begin and end at 12:01 A.M., Standard Time, at the *Policyholder's* address as stated in the Policy, and on the Application.

Signed for Fort Dearborn Life Insurance Company



Secretary



President

Basic Group Term Life Insurance Policy
with
Accidental Death & Dismemberment Benefits
Non-Participating

TABLE OF CONTENTS

PROVISION	PAGE
<i>Premium</i>	<i>3</i>
<i>Premium Rate Guarantee</i>	<i>3</i>
<i>Policy Termination</i>	<i>4</i>
<i>Additional Provisions</i>	<i>4</i>
<i>Rate Addendum</i>	<i>5</i>
<i>Application</i>	<i>Attached</i>

ATTACHMENTS:

- Master Application
- Certificate of Insurance

PREMIUM

How is the initial premium calculated?

Initial life, AD&D insurance premium is calculated in accordance with the rates set forth on the attached Rate Addendum.

When is premium paid?

The Policy is issued in consideration of the payment in advance of premium on the premium due date indicated on the *Application*. Payment must be made by the premium due date as shown on the *Application*.

If an addition, termination or change in insurance takes place other than on a regular due date, any premium adjustment will take effect on the next due date.

Is premium payable while an Insured receives benefits?

We will waive premium for an insured Employee in accordance with the Waiver of Premium provision of the Policy.

Is there a grace period for premium payment?

We will allow a grace period of 60 days for the payment of any premiums due except the first. Insurance coverage shall continue in force during the grace period unless the *Policyholder* has given *Us* advance written notice of cancellation in accordance with the terms of this Policy. If premium is not received by the end of the grace period, this Policy will terminate as of the last date for which premium was paid.

The *Policyholder* is liable for premium due on coverage provided during the grace period.

If *We* receive written notice during the grace period that the Policy is to be canceled, *We* will cancel it as of the later of:

1. the date requested in the cancellation notice; or
2. the date *We* receive such notice. The *Policyholder* must pay a pro rata premium for any coverage provided during the grace period.

PREMIUM RATE GUARANTEE

What is the initial premium rate guarantee?

A change in premium rates will not take effect before February 1, 2014. However, *We* may change premium rates if the risk assumed changes. Premium rates may change if the following occurs:

1. a change in the Policy design;
2. a change in the terms of the Policy;
3. addition or deletion of a division, subsidiary or affiliated company;
4. a change in the number of *Insureds* by 10% or more from the number of *Insureds* on the initial Effective Date;
5. a change in the laws or regulations or other government action which applies to the Policy;
6. for reasons other than 1-5 above such as but not limited to a change in factors bearing on the risk assumed.

The *Policyholder* must furnish notice and documentation satisfactory to *Us* within 31 days of the occurrence of any event which would cause a change in rates as described above. If the *Policyholder* fails to provide such timely notice, we will apply new rates retroactively to the date of the event.

We will notify the *Policyholder* in writing at least 31 days in advance of any premium rate changes. A change may take effect on an earlier date if both the *Policyholder* and *We* agree.

POLICY TERMINATION

Who may cancel the Policy or a plan under the Policy?

The Policy or a plan under the Policy can be canceled by the *Policyholder* with 31 days written notice delivered to *Us*. This Policy will terminate for any of the following reasons:

1. If the *Policyholder* fails to pay any premium within the 60-day Grace Period, this Policy will terminate in accordance with the terms set forth in the Grace Period provision.
2. We may terminate this Policy on any premium due date if:
 - a. coverage is *Noncontributory* and less than 100% of the eligible Employees participate; or
 - b. the *Policyholder* fails to perform any of its obligations that relate to the Policy; or
 - c. the *Policyholder* does not promptly provide *Us* with information that is reasonably required; or
 - d. fewer than 2 *Employees* are insured under the Policy.

If *We* cancel the Policy, for reasons other than the *Policyholder's* failure to pay premium, a written notice will be delivered to the *Policyholder* at least 31 days prior to the cancellation date.

ADDITIONAL PROVISIONS

What happens if an inadvertent error occurs?

Clerical error or omission by *Us* to the *Policyholder* will not:

1. Prevent an Employee from receiving coverage, if he is entitled to coverage under the terms of the Policy; or
2. Cause coverage to begin or coverage to continue for an Employee when the coverage would not otherwise be effective.

If the *Policyholder* gives *Us* information about an Employee that is incorrect, *We* will:

1. Use the facts to decide whether the Employee has coverage under the Policy and in what amounts; and
2. Make a fair adjustment of the premium.

Will certificates be issued?

We will deliver certificates of insurance to the *Policyholder* for issuance to each insured Employee. The certificates will describe the benefits, to whom they are payable, the Policy limitations and where the Policy may be inspected.

What is considered to be the entire contract?

This entire Policy consists of:

1. all Policy provisions and any amendments and/or attachments issued;
2. the Certificate of Coverage; and
3. the *Policyholder's* signed Application.

RATE ADDENDUM

(All Rates Per \$1,000 Per Month unless otherwise stated)

Class 01 Term Life: \$0.07

Class 01 Accidental Death & Dismemberment: \$0.02

STATE SUPPLEMENT

The following policies apply only to those individuals in your group insurance program who reside in the referenced states.

Arizona and Maine

Except as otherwise permitted by law, we will not disclose collected personal information about an individual to a nonaffiliated third party with whom we jointly offer products without giving the individual an opportunity to tell us that he or she does not want us to share his or her personal information.

Minnesota and Montana

Except as otherwise permitted by law, we will not disclose collected personal information about an individual to a nonaffiliated third party with whom we jointly offer products without obtaining the individual's written authorization.

Montana

Upon written request, an individual who has authorized the collection of health information is entitled to receive a record of Fort Dearborn's disclosures of any of his medical record information made within the preceding 3 years.

Oregon

An individual has the right to authorize disclosure of his or her personal information to an insurance company. An Oregon resident can exercise this right by requesting an authorization form in writing. Our address is:

Fort Dearborn Life Insurance Company®
1020 31st Street
Downers Grove, Illinois 60515

**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: 01/01/2013

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 above noted 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: <input type="checkbox"/> No Changes <input type="checkbox"/> See Additional Provisions				
To begin on Renewal Addendum Effective Date and continue for:				
<input checked="" type="checkbox"/> 12 Months <input type="checkbox"/> Other (please specify): _____ Months				
ADMINISTRATIVE CHARGE(S): <input type="checkbox"/> No Changes <input type="checkbox"/> See Additional Provisions				
Product / Service	PPO			
Base Administrative Charge (Medical)	\$36.19	\$	\$	\$
Prescription Drug Rebate Credit*	\$-5.00	\$	\$	\$
Choose an Item	\$	\$	\$	\$
Choose an Item	\$	\$	\$	\$
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.")	\$	\$	\$	\$
Blue Care Connection® ("BCC") Program: None	\$	\$	\$	\$
BCC Program Upgrade(s):	\$	\$	\$	\$
Description: None	\$	\$	\$	\$
Description: None	\$	\$	\$	\$
Special Beginnings	\$	\$	\$	\$
Other: _____	\$	\$	\$	\$
Other: _____	\$	\$	\$	\$
Other: _____	\$	\$	\$	\$
Total	\$31.19	\$	\$	\$

Dental: _____	\$	\$	\$	\$
Total	\$	\$	\$	\$
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:				<input type="checkbox"/> No Changes	<input type="checkbox"/> See Additional Provisions
Employer Payment Method:	<input type="checkbox"/> Online Bill Pay	<input checked="" type="checkbox"/> Electronic	<input type="checkbox"/> Check		
Employer Payment Period:	<input checked="" type="checkbox"/> Weekly (cannot be selected if Check is selected as payment method above)				
<input type="checkbox"/> Twice-Monthly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Other (please specify):			
Claim Settlement Period:	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> 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:				<input type="checkbox"/> No Changes	<input type="checkbox"/> See Additional Provisions
Product / Service					
Medical Run-Off Administrative Charge	\$13.17	\$	\$	\$	\$
Other: _____	\$	\$	\$	\$	\$

Dental Run-Off Administrative Charge	\$	\$	\$	\$
Other: _____	\$	\$	\$	\$

OTHER PROVISIONS:

1. Summary of Benefits & Coverage:

a) Claim Administrator will create Summary of Benefits & Coverage (SBC)?

- Yes. If yes, please answer question b. The SBC Addendum is attached.
- No. If No, then the Employer acknowledges and agrees that the Employer is responsible for the creation and distribution of the SBC as required by Section 2715 of the Public Health Service Act (42 USC 300gg-15) and SBC regulations (45 CFR 147.200), as supplemented and amended from time to time, and that in no event will the Claim Administrator have any responsibility or obligation with respect to the SBC. The Claim Administrator is not obligated to respond to or forward misrouted calls, but may, at its option, provide participants and beneficiaries with Employer's contact information. A new clause (e) is added to Subsection C. in the Additional Provisions as follows: "(e) the SBC". (Skip question b.)

b). Claim Administrator will distribute Summary of Benefits & Coverage (SBC) to participants and beneficiaries?

- No. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and provide SBC to Employer in electronic format. Employer will then distribute SBC to participants and beneficiaries (or hire a third party to distribute) as required by law.
- Yes. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and provide SBC to Employer in electronic format. Employer will then distribute to participants and beneficiaries as required by law, except that Claim Administrator will send the SBC in response to the occasional request received directly from individuals.
- Yes. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and distribute SBC to participants and beneficiaries via regular hardcopy mail or electronically. Distribution Fee for hardcopy mail is \$1.30 per package. The distribution fee will not apply to SBCs that Claim Administrator sends in response to the occasional request received directly from individuals

ADDITIONAL PROVISIONS:

Effective 1/1/2012 the minimum hours work per week should be 20 hours.

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 10/15/2012

Title Date
956-581-5615 / 312-540-3104

BCBSTX Telephone and Fax numbers
Alberto Trevino and Roberto Ramirez Jr.

Agent Representative (if applicable)
10/15/2012

Date
956-781-7771 and 956-783-1137

Agent Phone & Fax Numbers
Ocarrasco03@aol.com / rr@puroaseguro.com

Agent Email Address
454785551 / 455689870

Tax I.D. No.

Signature of Authorized Purchaser
County Judge

Title

Date





**BlueCross BlueShield
of Texas**

Hidalgo County

ASO Projection

for the period

January 1, 2013 - December 31, 2013

Hidalgo County # 21185 ASO Medical Renewal

TOTAL PROJECTED COST

Please refer to the ACA Disclaimer regarding benefits and final pricing.

All Employees	Fee	Total Cost
Projected Enrollment	3738	44,856
Individual Stop Loss (\$170,000 Level)	\$30.09	\$1,349,717
Administration Fee	\$36.19	\$1,623,339
Prescription Drug Rebate Credit	(\$5.00)	(\$224,280)
Net Administration Fee	\$31.19	\$1,399,059
Total Fixed Cost	\$61.28	\$2,748,776
Run-Off Administration	\$13.17	\$147,688

Signature of Authorized Purchaser

County Judge
Title

Date



Account Name: **HIDALGO COUNTY** Account Number: **021185** Renewal Date: **01/01/2013**

Grandfathered Health Plan Form

The Affordable Care Act (ACA) provides that a group health plan in which an individual was enrolled on March 23, 2010, (ACA's date of enactment) may be a "grandfathered health plan." Grandfathered health plans are not subject to certain ACA provisions.

By default, our group renewal offer(s) reflect a non-grandfathered health plan design. **This Grandfathered Health Plan Form must be signed by the group representative and returned to our offices at least 10 days prior to your renewal effective date in order to change your renewal(s) to a grandfathered health plan design.** If a plan is modified to a non-grandfathered health plan design on its effective date, it cannot later revert back to a grandfathered health plan design.

Complete the information on page 2 of this form to indicate whether your existing plan(s) qualify as grandfathered health plan(s) under the Affordable Care Act and related regulations. **Check all that apply for only the benefit plan(s) in effect that qualify for and that you wish to be administered with a grandfathered health plan design.** This information needs to be provided for all benefit plans in effect.

For more information on grandfathered health plans and what changes or events may cause a plan to lose grandfathered health plan status, go online to: bcbstx.com/affordable_care_act. If you have questions regarding this worksheet, contact your insurance broker (if applicable) or your BCBSTX account representative. The rules related to grandfathered health plans are complex. We recommend that you seek the advice and guidance of your legal counsel regarding ACA and grandfathered health plans. If you believe a plan or policy has lost or will lose grandfathered status, contact your insurance broker (if applicable) or BCBSTX representative immediately for available benefit plan options.

TO BE SIGNED BY THE GROUP REPRESENTATIVE:

I, the undersigned, a duly authorized representative of the plan sponsor named above ("Plan Sponsor"), hereby represent that I am knowledgeable as to standards associated with a "grandfathered health plan" as set forth in the Affordable Care Act and applicable regulations, and that the information contained in this Form and any subsequent updates to such Form, are true, accurate and complete; and (ii) agree that the Plan Sponsor will immediately provide BCBSTX with written notice prior to renewal (and during the plan year, with at least 60 days advance written notice) of any changes that would cause the Plan Sponsor's group health plan(s), including any benefit packages, to not qualify as a grandfathered health plan under ACA and applicable regulations.

Signature

Title

Print Name

Date



Account Name: HIDALGO COUNTY Account Number: 021185 Renewal Date: 01/01/2013

Grandfathered Health Plan Form

Table with 3 columns: Group Number, Plan/Benefit Agreement Name/Number, Grandfathered? (Yes/No checkboxes). Contains 18 rows of data.

Add additional details as needed by copying this page. Make sure you return the signature and table page(s) together.