



**BlueCross BlueShield
of Texas**

APPLICATION AND POLICY SCHEDULE FOR STOP LOSS COVERAGE

Employer Group Name: City of San Antonio
Employer Group Address: 100 W. Houston Street
City: San Antonio **State of Situs:** TX **Zip Code:** 78283
Account Number: 192417
Employer Group Number(s): 192417, 192418, 192419, 192420, 274255, 277574, 291522, 323346, 323347, 323348, 374748
Original Effective Date of Stop Loss Policy: 01/01/2024
Current Policy Effective Date: 01/01/2024
Current Policy Period The specifications set forth in this Application are for the Policy Period commencing on 01/01/2024 and ending on 12/31/2024.

The specifications below shall become effective on the first date 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dates: (1) The last day of the Policy Period; (2) The date the Policy terminates; or (3) The date this Application is superseded in whole or in part by a later executed Application.

A. Covered Employees:

Number of Single Coverage Units: 4,936
Number of Family Coverage Units: 6,729

B. Individual Stop Loss Coverage:

1. New Coverage ☒ Renewal of Existing Coverage ☐

2. Stop Loss coverage during the Current Policy Period

☒ 24/12

Coverage for Claims incurred from 01/01/2022 to 12/31/2024 and Claims paid from 01/01/24 to 12/31/2024.

If 24/12, 18/12, 15/12, or 12/12 are selected, Employer Group understands that run-out coverage is not included, and Employer Group represents that it intends to purchase run-in coverage from its next carrier.

For new coverage only, if a run-in contract as explained in the Stop Loss Policy (24/12, 18/12, or 15/12 coverage period) is purchased, claims paid by the Employer Group's prior claim administrator will be settled at the time of the annual stop loss settlement and must be reported by the Employer Group to the Company (Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) by the end of the Employer Group's Current Policy Period or stop loss coverage for these run-in claims will be forfeited.

☐ (Paid Renewal Only) Claim Administrators Claims: Claims incurred on or after the Original Effective Date of Policy and paid during the Policy Period.

3. Covered Expenses includes:

☒ Medical Claims:
☒ Prescription Drug Claims with: CVS _____

TX SL-APP Rev. 3.21

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

- ☐ For **Hospital Employer Groups only**: Excludes ____% of Home Hospital Medical claims
☐ Other (for example Dental/Vision): ____.

4. Individual Stop Loss Provisions

- a. Individual Stop Loss Deductible: \$1,200,000
Applies per Covered Person for the Employer Group's Current Policy Period.
- b. Aggregating Specific Deductible (if applicable): \$____
- c. Lasered Individuals with Individual Stop Loss Deductible (if applicable):
Individual identifier, alternate Individual Stop Loss Deductible:
\$____
- d. Lasered Individuals excluded from Stop Loss Coverage (if applicable):
Individual identifier:

- e. If a run-in contract (24/12, 18/12, or 15/12 coverage period) is purchased, per Item 2. above, run-in claims are covered with a maximum liability of: \$____ per Covered Person.

5. Terminal Liability Option (TLO) (does not apply to Employer Groups with 12/15, 12/18, or 12/24 contracts):

☐ Yes ☒ No

The following applies if the answer to item above is "Yes" (Terminal Liability Option):

Must be elected at Policy inception or renewal. Premium cost is calculated by taking the average enrollment for the last two months of the Current Policy Period multiplied by three times pre-termination Individual Stop Loss rate(s). Premium is due at the time of termination, payable by lump sum within 10 days of receipt of bill. Claims will accumulate and be combined under one Individual Stop Loss Deductible specified in item B.4.a above for the Current Policy Period and Terminal Period. The Settlement for the Final Accounting Period will be described in the section of the Policy entitled SETTLEMENTS.

6. Individual Stop Loss Premium

Monthly Individual Stop Loss Premium shall be equal to the amounts obtained by multiplying the number of Covered Employees for a particular Month by:

\$7.20 Composite; or
\$____ for each Single Coverage Unit
\$____ for each Family Coverage Unit

C. Aggregate Stop Loss Coverage: Yes ☐ No ☒

If yes, complete Items 1. through 5. Below:

1. New Coverage ☐ Renewal of Existing Coverage ☐

2. Stop Loss Coverage during the current Policy Period

☐ **Choose an item**

Coverage for Claims incurred from ____ to ____ and Claims paid from ____ to ____.

If 24/12, 18/12, 15/12, or 12/12 are selected, Employer Group understands that run-out coverage is not included, and Employer Group represents that it intends to purchase run-in coverage from its next carrier.

For new coverage only, if a run-in contract as explained in the policy (24/12, 18/12, or 15/12 coverage period) is purchased, claims paid by the Employer Group's prior claim administrator will be settled at the time of the annual stop loss settlement and must be reported by the Employer Group to the Company (Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) by the end of the Employer Group's Current Policy Period or stop loss coverage for these run-in claims will be forfeited.

☐ (Paid Renewal Only) Claim Administrators Claims: Claims incurred on or after the Original Effective Date of Policy and paid during the Policy Period.

3. Covered Expenses:

- ☐ Medical Claims
☐ Claim Administrator's Provider Access Fees
☐ Prescription Drug Claims with: **Choose an item** _____
☐ For **Hospital Employer Groups only**: Excludes _____% of Home Hospital Medical claims
☐ Other (for example Dental/Vision): _____

4. Aggregate Claim Liability

- a. Attachment Factor _____% of the Average Claim Value
b. Aggregate Claim Factors:

| | | | | |
|-------------------------------|----------|----------|----------|----------|
| Group Number: | _____ | _____ | _____ | _____ |
| Composite; or | \$ _____ | \$ _____ | \$ _____ | \$ _____ |
| For each Single Coverage Unit | \$ _____ | \$ _____ | \$ _____ | \$ _____ |
| For each Family Coverage Unit | \$ _____ | \$ _____ | \$ _____ | \$ _____ |

- c. Minimum Aggregate Point of Attachment: \$ _____

5. Terminal Liability Option (TLO) (does not apply to Employer Groups with 12/15, 12/18, or 12/24 contracts):

☐ Yes ☐ No

The following applies if the answer to item above is "Yes" (Terminal Liability Option):

Must be elected at Policy inception or renewal. Premium cost is calculated by taking the average enrollment for the last two months multiplied by three times pre-termination Aggregate Stop Loss rate(s). Premium is due at the time of termination, payable by lump sum within 10 days of receipt of bill.

The Final Settlement Point of Attachment shall equal the sum of the Employer's Aggregate Claim Liability amount for the Policy Period plus 15% of the Aggregate Claim Factor multiplied by 12, and then multiplied by the average enrollment for the last two (2) months of the Current Policy Period immediately preceding termination. Furthermore, for the Final Settlement Period, the Minimum Aggregate Point of Attachment shall be the Minimum Aggregate Point of Attachment in item C.4.c. above increased by 15%. The Settlement for the Final Accounting Period will be described in the section of the Policy entitled SETTLEMENTS.

6. Aggregate Stop Loss Premium:

☐ Monthly Premium

Monthly Aggregate Stop Loss Premium shall be equal to the amounts obtained by multiplying the number of Covered Employees for a particular Month by:

\$ _____ Composite; or
 \$ _____ for each Single Coverage Unit
 \$ _____ for each Family Coverage Unit

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

D. Additional Provisions (if elected):

1. Retirees Covered (select if included):
Pre-65: ☒ or Post-65: ☐
2. Home Hospital Employer Groups Only: Home Hospital Provider Number(s) subject to exclusion percentage per Item B.3. & C.3.: _____
3. Monthly Aggregate Accommodation: ☐ Yes ☐ No
4. Additional information: _____

Fraud Notice: Any person who knowingly, with intent to injure, defraud or deceive any insurance company submits an application containing any false, incomplete, or misleading information, may be subject to prosecution and may be found guilty of a felony under state law and subject to punishment, including fines and/or imprisonment. Submission of false information in connection with this application may also constitute a crime under federal laws. All appropriate legal remedies will be pursued in the event of insurance fraud, including prosecution under Federal Mail or Wire Fraud statutes, and/ or the Federal Racketeer Influenced and Corrupt Organizations Act. Any false statements made herein may be reported to state and federal tax and regulatory authorities as is appropriate.

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 and 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".

Brandon McCorkle
Sales Representative

Signature of Authorized Purchaser

Title of Authorized Purchaser

Date