Benefit Program Application ("ASO BPA")

Application 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 the "Claim Administrator" or "HCSC"

Group Status: Former HCSC Insured account converting to ASO

Employer Account Number (6-digits): 217766 Group Number(s): _____ Section Number(s): All

Legal Employer Name: South San Antonio ISD

(Specify the Employer or the employee trust applying for coverage. Names of subsidiary or affiliated companies to be covered must also be named below. AN EMPLOYEE BENEFIT PLAN *MAY NOT* BE NAMED)

ERISA Regulated Group Health Plan*: ☐ Yes ☒ No

Is your ERISA Plan Year* a period of 12 months beginning on the Anniversary Date specified below? ☒Yes
If not, please specify your ERISA Plan Year*: Beginning Date __/__/__ End Date __/__/__ (month/day/year)

ERISA Plan Administrator*: _____ Plan Administrator's Address: _____

If you maintain that ERISA is not applicable to your group health plan, give legal reason for exemption:
Select legal reason ; if applicable, specify other: _____

Is your Non-ERISA Plan Year* a period of 12 months beginning on the Anniversary Date specified below? ☒Yes
If not, please specify your Non-ERISA Plan Year*: Beginning Date 11 /01/2018 End Date 10/31/2019 (month/day/year)

For more information regarding ERISA, contact your Legal Advisor.
*All as defined by ERISA and/or other applicable law/regulations

Effective Date of Coverage: (Month/day/Year) 11 / 01 / 2018

Anniversary Date: (Month/Day/Year) 11 / 01 / 2019

Account Information ☐ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

Standard Industry Code (SIC): 8211 Employer Identification Number (EIN): 74-6002335

Address: 5622 Ray Ellison Blvd.

City: San Antonio State: TX ZIP: 78242

Administrative Contact: Irma Paine Title: Human Resource Coordinator

Email Address: ipaine@southsanisd.net Phone Number: 210-977-7040 Fax Number: 210-977-7017

☐ Mailing address is different from primary address

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Mailing Contact: Irma Paine Title: Human Resource Coordinator

Email Address: ipaine@southsanisd.net Phone Number: 210-977-7040 Fax Number: 210-977-7017

☐ Billing address is different from primary address

Billing Address: _____

City: _____ State: _____ ZIP: _____

Billing Contact: Irma Paine Title: Human Resource

Email Address: ipaine@southsanisd.net Phone Number: 210-977-7040 Fax Number: 210-977-7017

Wholly Owned Subsidiaries: n/a

Affiliated Companies: _____

(If Affiliated Companies listed above are to be covered, a separate "Addendum to the ASO BPA Regarding Affiliated Companies" must be completed, signed by the Employer's authorized representative, and attached to this ASO BPA.)

Subsidiary / Affiliate Address: _____

City: _____ State: _____ ZIP: _____

Subsidiary / Affiliate Contact: _____ Title: _____

Email Address: _____ Phone Number: _____ Fax Number: _____

Blue Access for Employers (BAE) Contact: Stephanie Mendoza Title: General Accountant

(The BAE Contact is the Employee authorized by the Employer to access and maintain the Employer's account in BAE.)

Email Address: smendoza@southsanisd.net Phone Number: 210-977-7025 Fax Number: 210-977-7019

☒ The Employer or other company listed in this BPA is a is a public Entity or governmental agency/contractor

Producer of Record **NO CHANGES** **SEE ADDITIONAL PROVISIONS**

Effective: 11/01/2018

If applicable, the below-named producer(s) or agency(ies) is/are recognized as the Employer's Producer of Record (POR) to act as representative in negotiations with and to receive commissions from Blue Cross and Blue Shield of Texas, a division of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company, and HCSC subsidiaries for Employer's employee benefit programs. This statement rescinds any and all previous POR appointments for the Employer. The POR is authorized to perform membership transactions on behalf of the Employer. This appointment will remain in effect until withdrawn or superseded in writing by Employer.

Producer or Agency to whom commissions are to be paid*: Gallagher Benefit Services

Tax ID Number (TIN) of ☐ Producer or ☒ Agency: 364291971 Producer #: 000022147

NPN: _____

Address: The Gallagher Centre, Two Pierce Place

City: Itasca State: IL ZIP: 60143

Phone: _____ Fax: _____ Email: _____

Is Producer/Agency appointed with HCSC in Texas? ☒ Yes ☐ No

General Agent? ☐ Yes ☒ No

Affiliated with General Agent? ☐ Yes ☐ No

Is there a secondary Producer or Agency to whom commissions are to be paid? ☐ Yes ☒ No

If Yes, Producer or Agency to whom commissions are to be paid*:** _____

Tax ID Number (TIN) of ☐ Producer or ☐ Agency: _____ Producer #: _____

NPN: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____ Email: _____

Is Producer /Agency appointed with HCSC in Texas? ☐ Yes ☐ No

General Agent? ☐ Yes ☐ No

Affiliated with General Agent? ☐ Yes ☐ No

If commission split**, designate percentage for each producer/agency (total commissions paid must equal 100%):

Producer /Agency 1: _____% Producer /Agency 2: _____%

Multiple Location Agency(ies): If servicing agency is not listed above as primary or secondary Producer or Agency above, specify location below:

_____

* The Producer or agency name(s) above to whom commissions are to be paid must exactly match the name(s) on the appointment application(s).

** If commissions are split, please provide the information requested above on both producers/agencies. **Both** must be appointed to do business with HCSC in Texas.

Schedule of Eligibility **NO CHANGES** **SEE ADDITIONAL PROVISIONS**

Employer has made the following eligibility decisions

1. Eligible Person means:
   - ☒ A full-time employee of the Employer.
   - ☐ A full-time employee of the Employer who is a member of: _____ *(name of union)*
   - ☐ A part-time employee of the Employer.
   - ☐ A retiree of the Employer. Define criteria: _____
   - ☐ Other: _____

   Are any classes of employees to be excluded from coverage? ☐ Yes ☒ No

   If yes, please identify the classes and describe the exclusion: _____

2. Employee Definitions:

   Full-Time Employee means:

☒ A person who is regularly scheduled to work a minimum of 30 hours per week and who is on the permanent payroll of the Employer.

☐ Other: _____

Part-Time Employee means:

☐ A person who is regularly scheduled to work a minimum of _____ hours per week and who is on the permanent payroll of the Employer.

☐ Other:

3. The Effective Date of termination for a person who ceases to meet the definition of Eligible Person:

   ☐ The date such person ceases to meet the definition of Eligible Person.

   ☒ The last day of the calendar month in which such person ceases to meet the definition of an Eligible Person

   ☐ Other: _____

4. Select an effective date rule for a person who becomes an Eligible Person after the Effective Date of the Employer's health care plan (The effective date must not be later than the 91st calendar day after the date that a newly eligible person becomes eligible for coverage, unless otherwise permitted by applicable law).

   ☐ The date of employment.

   ☐ The day of employment.

   ☐ The day of the month following month(s) of employment.

   ☐ The day of the month following days of employment.

   ☒ The1st day of the month following the date of employment.

   ☐ Other:

   Is the waiting period requirement to be waived on initial group enrollment? ☐ Yes ☒ No

   Are there multiple new hire waiting periods? ☐ Yes ☒ No

   If yes, please attach eligibility and contribution details for each section.

5. Domestic Partners covered? ☒ Yes ☐ No

   If yes: *a Domestic Partner is eligible to enroll for coverage.*

   If yes, are Domestic Partners eligible for continuation of coverage? ☒ Yes ☐ No

   If yes, are dependents of Domestic Partners eligible for coverage? ☒ Yes ☐ No

   If yes, are dependents of Domestic Partners eligible for continuation of coverage? ☒ Yes ☐ No

   The Employer is responsible for providing notice of possible tax implications to those Covered Employees with coverage for Domestic Partners.

6. Limiting Age for covered children: Twenty-six (26) years, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage, or any combination of those factors. Other:

7. Are unmarried step-children under the limiting age eligible for coverage? ☒ Yes ☐ No

   If yes, is residency with the employee required? ☐ Yes ☒ No

8. Are unmarried grandchildren eligible for coverage?

   ☐ No ☒ Yes (answer the question below)

   Must the grandchild be dependent on the employee for federal income tax purposes at the time application is made? ☒ Yes ☐ No

9. Termination of coverage upon reaching the Limiting Age:

   ☐ The last day of coverage is the day prior to the birthday.

   ☒ The last day of coverage is the last day of the month in which the limiting age is reached.

   ☐ The last day of coverage is the last day of the billing month.

   ☐ The last day of coverage is the last day of the year (12/31) in which the limiting age is reached.

   ☐ The last day of coverage is the day prior to the Employer's Anniversary Date.

   Automatically cancel dependents when they reach the day their coverage terminates ☒ Yes ☐ No

   Will coverage for a child who is medically certified as disabled and dependent on the employee terminate upon reaching the limiting age even if the child continues to be both disabled and dependent on the employee?

☐ Yes ☒ No

However, such coverage shall be extended in accordance with any applicable federal or state law. *The Employer will notify HCSC of such requirements.*

10. Will extension of benefits due to temporary layoff, disability or leave of absence apply?

    ☐ Yes (specify number of days below) ☒ No

    Temporary Layoff: 0 days Disability:0 days Leave of Absence: 0 days

    However, benefits shall be extended for the duration of an Eligible Person's leave in accordance with an applicable federal or state law. The Employer will notify HCSC of such requirements.

11. Enrollment:

    Special Enrollment: An Eligible Person may apply for coverage, Family coverage or add dependents within thirty-one (31) days of a Special Enrollment qualifying event if he/she did not previously apply prior to his/her Eligibility Date or when otherwise eligible to do so. Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be the effective date of the qualifying event or, in the event of Special Enrollment due to marriage or termination of previous coverage, then no later than the first day of the Plan Month following the date of receipt of the person's application of coverage.

    An Eligible Person may apply for coverage within sixty (60) days of a Special Enrollment qualifying event in the case either of a loss of coverage under Medicaid or a state Children's Health Insurance program, or eligibility for group coverage where the Eligible Person is deemed qualified for assistance under a state Medicaid or CHIP premium assistance program.

    Late Enrollment: An Eligible Person may apply for coverage, family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so. Such person's Coverage Date, family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by the Claim Administrator and the Employer.

    ☒ Annual open enrollment – late applicant may apply during open enrollment and be subject to the late applicant provisions.

    ☐ Late applicants may apply at any time – coverage is effective first of the month following receipt of the application.

    Open Enrollment: An Eligible Person may apply for coverage, family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so, during the Employer's Open Enrollment Period. Such person's Coverage Date, family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by the Claim Administrator and the Employer. Such date shall be subsequent to the Open Enrollment Period.

    Specify Open Enrollment Period: August 15th - September 15th

12. * Does COBRA Auto Cancel apply? ☒ Yes ☐ No

    Member's COBRA/Continuation of Coverage will be automatically cancelled at the end of the member's eligibility period.

    **Not recommended for accounts with automated eligibility*

CURRENT ELIGIBILITY INFORMATION

☐ **NO CHANGES** ☐ **Current number of Employees enrolled _____** ☐ **SEE ADDITIONAL PROVISIONS**

Current Employee Eligibility Information only applies to new accounts. If your account is renewing, please just indicate the current number of enrolled employees (above).

Total number of Employees/Subscribers:

1. on payroll _____
2. total number of employees presently eligible for coverage _____
3. on COBRA continuation coverage _____
4. with retiree coverage (if applicable) _____
5. who work part-time _____
6. serving the new hire waiting period _____
7. declining because of other **group** coverage (e.g., other commercial group coverage, Medicare, Medicaid, TRICARE/Champus) _____
8. declining coverage (not covered elsewhere) _____

Lines of Business (Check all applicable services)	NO CHANGES See *Additional Comments*
Medical Plan Services: ☒ PPO: Plan Name: Option 2 PPO $6000 Plan Name: Option 3 PPO $3000 Plan Name: Option 4 PPO $4,000 Plan Name: _____ Plan Name: _____ ☒ HMO: Plan Name: ☐ Prescription Drug Option: Select From List ☒ No Prescription Drug Option ☐ EPO: Plan Name: _____ ☐ POS: Plan Name: _____ ☐ Blue Directions (Private Exchange) (*If selected, the Blue Directions Addendum must be attached and made a part of the Agreement.)*	**Consumer Driven Health Plan (BlueEdge)** ☐ HCA, (*if selected, complete separate HCA Benefit Program Application*) ☐ HSA, (*if selected, provide HSA Administrator or trustee name:* _____) ☐ FSA (vendor: ConnectYourCare) **Traditional Coverage:** ☐ Out-of-Area (Indemnity) ☐ Benefit Offering **Prescription Drugs:** ☐ Prescription Drug Program ☐ Stand-Alone Prescription Drug Program
☐ **Dental Plan Services** Plan Name: _____ Select From List Plan Name: _____ Select From List Plan Name: _____ Select From List Plan Name: _____ Select From List Plan Name: _____ Select From List ☒ **Stop Loss Coverage** (*If selected, complete separate Stop Loss exhibit*) ☐ **Dearborn National Life Insurance** (*If selected, complete separate Life application*) ☐ **COBRA Administrative Services** (*If selected, complete separate COBRA Administrative Services*	☐ **Vision Plan Services** ☐ **In-Hospital Indemnity (IHI)** ☐ **Wellness Incentives** ☐ Other Select Product ☐ Other Select Product ☐ Other Select Product ☐ Other Select Product ☐ Other ☐ Other

Additional Comments: South San Antonio ISD will renew moving from Fully Insured to ASO. The PPO plans will remain the same as current benefits and the Blue Essentials will be a Gatekeeper plan with same benefits. MDLive (medical and behavioral health) included. BVA and Member Rewards available to members on PPO plans. PBM will be ESI, we will

share accums and reverse eligibility will be set up. Stop Loss at $200K ISL 115% attachment. Monthly ACAP included and applies to medical claims only. RX will be included in Stop Loss at year end settlement. Includes a transition credit in the amount of $15,000 and Wellness Credit in the amount of $25,000. Both Transition and Wellness credits are for the policy period 11/1/2018 through 10/31/2019. Any remaining balance will expire after 10/31/2019.

FEE SCHEDULE

Payment Specifications	NO CHANGES	SEE ADDITIONAL PROVISIONS

Employer Payment Method: ☐ **Online Bill Pay** ☐ **Electronic** ☐ **Auto Debit** ☐ **Check**

Employer Payment Period: ☒ **Weekly** (cannot be selected if Check is selected as payment method above)
☐ **Semi 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 the end of the Fee Schedule Period.
Standard is twelve (12) months.

Final Settlement: Final Settlement to be made within **90** days after end of Run-Off Period.
Standard is ninety (90) days.

Fee Schedule Period: To begin on Effective Date of Coverage and continue for 12 months. If other than 12 months, please specify: 12 Months.

Administrative Per Employee per Month (PEPM) Charges	NO CHANGES	SEE ADDITIONAL PROVISIONS		
	11-2018	12-2018 through 10-31-2019	11-2019	11-2020
Administrative Fee	$17.84	$39.60	$38.43	$40.35
Dental	$_____	$_____	$_____	$_____
Claims Fiduciary	$included in admin	$included in admin	$tbd	$tbd
Outpatient Imaging Management Services	$_____	$_____	$_____	$_____
Management of the Virtual Visits Program	$_____	$_____	$_____	$_____
Commissions	$_____	$_____	$_____	$_____
Other: Other Services List Service: MD Live	$0.00	$0.00	$tbd	$tbd
Other: Other Services List Service: BVA with Member Rewards	$1.70	$1.70	$tbd	$tbd
Other: Other Services List Service: RX Shared Accums Maintenance	$.42	$.42	$tbd	$tbd
Miscellaneous: $25,000 Wellness Credit	$0.00	$0.00	$tbd	$tbd
Miscellaneous: $15,000 Transition Dollars	$0.00	$0.00	$tbd	$tbd
Total	$19.96	$41.72	$_____	$_____

Administrative Line Item Charges	Frequency	Amount
Other: Other Services List Service: Reverse Eligibility (RX carveout)	Annual If applicable, describe other: _____	$2,000
Other: Other Services	One-time fee	$2,000

List Service: Shared Accumulator Set Up (RX carveout)	If applicable, describe other: _____	
Other: None List Service: _____	Annual If applicable, describe other: _____	$_____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	$_____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	$_____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	$_____
	Total:	**$4,000**

Additional Comments (Provide any additional details regarding the fee structure): _____

Other Service and/or Program Fee(s) **NO CHANGES** **SEE ADDITIONAL PROVISIONS**

Not applicable to Grandfathered Plans

External Review Coordination: ☒ Yes ☐ No If yes, coordination fee: $700 for each external review requested by a Covered Person that the Claim Administrator coordinates for the Employer in relation to the Employer's Plan. Employer elects for external reviews to be performed under the Federal Affordable Care Act external review process.

Reimbursement Service: ☒ Yes ☐ No

If yes*:* The Employer has elected to utilize the reimbursement service offered by the Claim Administrator, the Corporate Reimbursement Subrogation department. It is understood and agreed that in the event the Claim Administrator makes a recovery on a third-party liability claim, the Claim Administrator will retain 25% of any recovered amounts other than recovered amounts received as a result of or associated with any Workers' Compensation Law.

Claim Administrator's Third Party Recovery Vendors and Law Firms (other than Reimbursement Services):

Employer will pay no more than 25% of any recovered amount made by Claim Administrator's Third Party Recovery Vendor. Employer will pay no more than 35% of any recovered amount made by Claim Administrator's third party law firm.

Alternative Compensation Arrangements: Employer acknowledges and agrees that Claim Administrator has Alternative Compensation Arrangements with contracted providers, including but not limited to Accountable Care Organizations and other Value Based Programs. Further information concerning Employer's payment for covered services under such Arrangements is described in the Administrative Services Agreement.

Virtual Visits Program: ☒ Yes ☐ No If yes, Covered Persons would be able to obtain certain Covered Services remotely via video or audio only (where available) capability from Providers participating in the Virtual Visit program.

Termination Administrative Charges

As applies to the Run-Off Period indicated in the Payment Specifications section above:

The Termination Administrative Charge applicable to the Run-Off Period shall be equal to the sum of the amounts obtained by multiplying the total number of Covered Employees by category *(per Covered Employee per individual or family composite)* during the three (3) months immediately preceding the date of termination by the appropriate factors shown below.

Service	11/1/2018			
Medical Run-off Administration Charge	$11.40	$_____	$_____	$_____
Dental Run-off Administration Charge	$_____	$_____	$_____	$_____
Miscellaneous	$_____	$_____	$_____	$_____
Miscellaneous	$_____	$_____	$_____	$_____
Total:	**$11.40**	$_____	$_____	$_____

Additional Comments: _____

Other Provisions	NO CHANGES	SEE ADDITIONAL PROVISIONS

1. Summary of Benefits & Coverage:
   a. Will Claim Administrator create Summary of Benefits & Coverage (SBC)?

      ☒ Yes. (Please answer question b. The SBC Addendum is attached.)
      ☐ No. If No, then skip question b and refer to the Administrative Services Agreement for further information.

   b. Will Claim Administrator distribute the 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 $1.50 per package. The distribution fee will not apply to SBCs that Claim Administrator sends in response to the occasional request received directly from individuals.

2. Does the Employer direct Claim Administrator to provide written statements of creditable coverage to its Covered Employees who reside, or have enrolled dependents who reside, in Massachusetts and file electronic reports to the Massachusetts Department of Revenue in a manner consistent with the requirements under the Massachusetts Health Care Reform Act? ☒ Yes ☐ No

   If no: The Employer acknowledges it will provide written statements and electronic reporting to the Massachusetts Department of Revenue as required by the Massachusetts Health Care Reform Act.

3. Case Management Program: ☒ Yes ☐ No *If yes: The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons.*

4. Employer acknowledges and agrees to utilize Claim Administrator's standard list of services and supplies for which pre-notification or preauthorization is required: ☒ Yes ☐ No If no, Employer authorizes Claim Administrator to post Employer's pre-notification or preauthorization requirements on Claim Administrator's Website: ☐ Yes ☐ No

5. Essential Health Benefits ("EHB") Election:

   Employer elects EHBs based on the following:

   ☒ 1. EHBs based on a HCSC state benchmark: ☐ Illinois ☐ Oklahoma ☐ Montana ☒Texas ☐ New Mexico

   ☐ 2. EHBs based on benchmark of a state other than IL, MT, NM, OK and TX
   If so, indicate the state's benchmark that Employer elects: _____

   ☐ 3. Other EHB, as determined by Employer.

   In the absence of an affirmative selection by Employer of its EHBs, then Employer is deemed to have elected the EHBs based on the Texas benchmark plan.

6. Employer contribution:

Employer Contribution – Medical	Employer Contribution – Dental
_____ % of Employee's premium, or $HMO $342.33, PPO $355.89	_____ % of Employee's premium, or $_____
_____ % of Dependent's premium, or $_____	_____ % of Dependent's premium, or $_____

Comments: _____

7. This ASO BPA is binding on both parties and is incorporated into and made a part of the Administrative Services Agreement with both such documents to be referred to collectively as the "Agreement" unless specified otherwise.
8. Producer/Consultant Compensation

   The Employer acknowledges that if any producer/consultant acts on its behalf for purposes of purchasing services in connection with the Employer's Plan under the Administrative Services Agreement to which this ASO BPA is attached, the Claim Administrator may pay the Employer's producer/consultant a commission and/or other compensation in connection with such services under the Agreement. If the Employer desires additional information regarding commissions and/or other compensation paid the producer/consultant by the Claim Administrator in connection with services under the Agreement, the Employer should contact its producer/consultant.

Additional Provisions: _____

I UNDERSTAND AND AGREE THAT:

1. **Only complete for new accounts:** Receipt by HCSC of the advance administrative fee (where applicable), in the amount of $n/a, and completed enrollment forms does not constitute approval and acceptance by the HCSC Home Office.
2. HCSC will report the value of all remuneration by HCSC to ERISA plans with 100 or more participants for use in preparation of ERISA Form 5500 schedules. Reporting will also be provided upon request to non-ERISA plans or plans with fewer than 100 participants. Reporting will include base commissions, bonuses, incentives, or other forms of remuneration for which your Producer/consultant is eligible for the sale or renewal of self-funded and/or insured products.

Signature

Rae M. Bailey
Sales Representative

025 — 512-558-5121
District — Phone & FAX Numbers

Producer Representative

Producer Firm

Producer Address

Producer Phone & FAX Numbers

Producer Email Address

Tax I.D. No.

Signature of Authorized Purchaser

Print Name

Title

Date

PROXY

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than thirty (30) nor more than sixty (60) days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least twenty (20) days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

From time to time, HCSC pays indemnification or advances expenses to a director, officer, employee or agent consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

Group No.: ______________ By: ____
Print Signer's Name Here

➡ ____
Signature and Title

Group Name: South San Antonio ISD

Address: 5622 Ray Ellison Blvd.

City: San Antonio State: TX ZIP: 78242

Dated this ______________ day of ______________________
Month Year