



Transamerica Premier Life Insurance & Retiree RxCare 2020 Renewal Notice and Benefit Confirmation

Group: Webb County

Anniversary Date: 1/1/2020

Below are the new renewal rates for TPLIC medical and Retiree RxCare prescription drug coverages. Please initial and complete each section below. Authorized signature on the following page is required to confirm and accept your group's renewal.

RETIREE MEDICAL

Attained Age	Current Rates	New Rates Effective 1/1/2020
65 – 69	\$159.91	\$167.41
70 – 74	\$191.94	\$201.04
75 – 79	\$226.69	\$237.52
80 - 84	\$258.75	\$271.19
85 – 89	\$286.05	\$299.85
90+	\$299.09	313.54

_____ Initial to accept 2020 retiree medical rates

RETIREE RXCARE - PRESCRIPTION PART D

Current Rate

\$198.37

New Rate Effective 1/1/2020

\$204.32

_____ Initial to accept 2020 retiree prescription rate.

BILLING AND CONTRIBUTION SCHEDULE

List Bill – A monthly invoice will be sent directly to the designated billing contact.

- Group is responsible for collecting premiums from the retirees/spouses.
- Group is responsible for submitting payment in full directly to TPLIC.
- Please indicate contribution amount paid per month below.

	Amount Group Pays	Amount Retiree Pays
Medical Premium	\$ _____	\$ _____
RX Premium	\$ _____	\$ _____

CountyChoice Silver
Member Contact Designations
Webb County

Contracting Authority: As specified in the Interlocal Participation Agreement, each Member hereby designates and appoints a Contracting Authority of department head rank or above and agrees that TAC HEBP shall NOT be required to contact or provide notices to ANY OTHER person. Further, any notice to, or agreement by, a Member's Contracting Authority, with respect to service or claims hereunder, shall be binding on the Member. Each Member reserves the right to change its Contracting Authority from time to time by giving written notice to TAC HEBP. Please complete each category below:

Name: _____
Title: _____
Address: _____

Phone: _____
Fax: _____
Email: _____

Primary Contact: Main contact for daily matters pertaining to the retiree benefits.

Name: _____
Title: _____
Address: _____

Phone: _____
Fax: _____
Email: _____

Billing Contact: Responsible for receiving all invoices relating to retiree benefits.

Name: _____
Title: _____
Address: _____

Phone: _____
Fax: _____
Email: _____
HIPAA Secured FAX number: _____

Signature of County Judge or Contracting Authority

Date

Please PRINT Name and Title