BlueCross BlueShield of Texas
1001 E. Lookout Drive
Richardson, Texas 75082

BENEFIT PROGRAM APPLICATION ("BPA")

Blue Cross and Blue Shield of Texas (herein called "BCBSTX")

STANDARDIZED MID-MARKET GROUP PLANS*

Account Status: ☐ New ☐ Existing with Changes

Off Cycle Change: ☐ Yes ☐ No ☐ Former BCBSTX ASO converting to fully insured

Account Number (6-digits): _____ Group Number(s): _____

Policy Effective Date: _____ Policy Anniversary Date: _____

Legal Account Name: _____

(Specify the Employer or the employee trust applying for coverage. An employee benefit plan may not be named)

*Mid-Market Group Plans receive the same benefits as those required for large employers

☐ NO CHANGES GROUP INFORMATION

Employer Identification Number ("EIN"): _____

SIC: _____ Nature of Business: _____

Primary (Mailing) Address: _____

City: _____ State: _____ Zip: _____

Administrative Contact: _____ Title: _____

Phone: _____ Fax: _____

Email: _____

Blue Access for Employers℠ ("BAE℠") Contact:

_____ Title: _____

The BAE Contact is an Employee of the account who is authorized by the Employer to access and maintain the account in BAE.

Phone: _____ Fax: _____

Email: _____

Administrative Contact (if different from Primary):

_____ Title: _____

Phone: _____ Fax: _____

Email: _____

Physical Address (if different from Primary - required): _____

City: _____ State: _____ Zip: _____

Contact: _____ Title: _____

Phone: _____ Fax: _____

Email: _____

Billing Address (if different from Primary): _____

City: _____ State: _____ Zip: _____

Billing Contact: _____ Title: _____

Phone: _____ Fax: _____

Email: _____

Do you cover any wholly owned subsidiary or affiliated companies? ☐ Yes ☐ No If yes, please list below:

Subsidiary Companies to be covered (if more than one, list within the Additional Provisions):

_____

Subsidiary Address: _____

City: _____ State: _____ Zip: _____

Contact: _____ Title: _____

Phone: _____ Fax: _____

Email: _____

Affiliated Companies to be covered (if more than one, list within the Additional Provisions):

_____

Locations: _____

The **Employee Retirement Income Security Act of 1974 (ERISA)** is a federal law that sets minimum standards for employee benefit plans in the private industry. In general, **all** employer groups, insured or ASO, are subject to ERISA provisions except for governmental entities, such as municipalities and public school districts, and "church plans" as defined by the Internal Revenue Code.

ERISA Regulated Group Health* Plan: ☐ Yes ☐ No

If Yes, is your ERISA Plan Year* a period of twelve (12) months beginning on the Anniversary Date specified above? ☐ Yes ☐ No

If no, please specify your ERISA Plan Year (month/day/year): Beginning Date ____/____/____ End Date ____/____/____

ERISA Plan Administrator*: _____

Plan Administrator's Address: _____

If you maintain that ERISA is not applicable to your group health plan, please give legal reason for exemption:

☐ Federal Governmental plan (e.g., the government of the United States or agency of the United States)

☐ Non-Federal Governmental plan (e.g., the government of the State, an agency of the state, or the government of a political subdivision, such as a county or agency of the State)

☐ Church plan

☐ Other; please specify: _____

Is your Non-ERISA Plan Year a period of twelve (12) months beginning on the Anniversary Date specified above? ☐ Yes ☐ No

If no, please specify your Non-ERISA Plan Year (month/day/year): Beginning Date ____/____/____ End Date ____/____/____

For more information regarding ERISA, contact your Legal Advisor.

*All as defined by ERISA and/or other applicable law/regulations

☐ **NO CHANGES** **PRODUCER OF RECORD INFORMATION**

1. *Producer/Agency** name to whom commissions are to be paid:_____
Producer Number of ☐ Producer or ☐ Agency: _____
Street Address: _____
City: _____ Zip: _____
Phone: _____ Fax: _____
Email: _____
Is Producer/Agency appointed with BCBSTX? ☐Yes ☐No Affiliated with General Agent? ☐ Yes ☐ No
Commissions: $ PCPM

2. *Producer/Agency** name to whom commissions are to be paid:_____
Producer Number of ☐ Producer or ☐ Agency: _____
Street Address: _____
City: _____ Zip: _____
Phone: _____ Fax: _____
Email: _____
Is Producer/Agency appointed with BCBSTX? ☐ Yes ☐ No Affiliated with General Agent? ☐ Yes ☐ No
Commissions: $ PCPM

If commission split, designate percentage for each producer/agency.
Note: total commissions paid must equal one hundred percent (100%)
Producer/Agency 1: _____% Producer/Agency 2: _____%

3. Writing Producer's Name (please print): _____
Producer Number: _____ Phone: _____ Email: _____
Writing Producer 's Signature: _____ Date: _____

4. General Agent (GA) Override? ☐ Yes ☐ No General Agent Name: _____
BCBS TX GA#: _____ Email: _____
Address: _____
City: _____ Zip: _____
Health Override Amount (if applicable): _____ Dental Override Amount (if applicable): _____

If applicable, effective _____, the named producer(s)or agency(ies) is/are recognized as Employer's Producer of Record (POR), to act as representative in negotiations with and to receive commissions from BCBSTX and/or corporate subsidiaries, as applicable, for procuring fully insured coverage for Employer's employee benefit program(s). This statement rescinds any and all previous POR appointments for Employer. The POR is authorized to perform membership transactions on behalf of Employer. This appointment will remain in effect until withdrawn or superseded in writing by Employer.

General Agent's Signature: _____ Date: _____

*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 BCBSTX.

☐ **NO CHANGES** **SCHEDULE OF ELIGIBILITY**

1. **Standard Eligibility Provisions:** Eligible Employee/Subscriber means an Employee who works on a full-time basis, who usually works at least thirty (30) hours a week, and who otherwise meets the Participation Criteria established by an Employer. The term includes a sole proprietor, a partner, and an independent contractor, if the individual is included as an Employee under a Health Benefit Plan of a large Employer regardless of the number of hours the sole proprietor, partner, or independent contractor works weekly, but only if the plan includes at least two (2) other Eligible Employees who work on a full-time basis and who usually work at least thirty (30) hours a week. Participation Criteria means any criteria or rules established by a large Employer to determine the Employees who are eligible for enrollment or continued enrollment under the terms of a Health Benefit Plan. The Participation Criteria may not be based on Health Status Related Factors.

(HMO only) The Eligible Subscriber must reside, live or, work in the Service Area.

2. **Other Eligibility Provisions (check all that apply):**

☐ Retiree of the Employer

☐ Other: _____

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

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

Domestic Partners covered: ☐ Yes ☐ No

A Domestic Partner means a person with whom the Employee has entered into a domestic partnership in accordance with the Employer's plan guidelines. The Employer is responsible for providing notice of possible tax implications to those covered Employees with Domestic Partners. An Employer may only elect or change Domestic Partner Coverage on the Policy Effective Date or Policy Anniversary Date.

Continuation coverage for Domestic Partners: If Employer elects coverage for Domestic Partners, a Domestic Partner is eligible for continuation coverage under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) if an eligible Employee elects COBRA coverage. Employer may also elect whether to provide continuation coverage for Domestic Partners on an independent basis from the Employee. Please indicate your election below:

☐ Yes, Employer elects to offer continuation coverage to Domestic Partners on an independent basis from an Employee's election of COBRA.

☐ No, Employer does not elect to offer continuation coverage to Domestic Partners on an independent basis from an Employee's election of COBRA (Domestic Partners are not independently eligible for continuation coverage)

☐ Other: _____

3. All current and new Employees must satisfy the substantive eligibility criteria and required Waiting Period in order for coverage to become effective. Covered Dependents do not have to satisfy a Waiting Period to become effective, but in no instance shall a Dependent be covered prior to the Employee's effective date.

If a person is added to the Policy and it is later determined that the Policyholder reported a coverage date earlier than what would apply to the Employee or Dependent, based on the Waiting Period and eligibility conditions the Policyholder provided to the Plan, the Plan reserves the right to retroactively adjust the coverage date for such person.

What is the effective date for a newly eligible person who becomes effective after the Employer's initial enrollment?

☐ The _____ day (standard is first (1st) or fifteenth (15th)) of the month following the date of employment.

☐ The _____ day (standard is first (1st) or fifteenth (15th)) of the month following select one days of employment.

☐ The _____ day (standard is first (1st) or fifteenth (15th)) of the month following select one month(s) of employment.

☐ The date of employment (date of hire).

☐ 15/16 Day Rule – premiums will be billed for the entire month for Participants with effective dates on the first (1st) through the fifteenth (15th) day of the month. Premiums will not be billed for the month when the Participant's effective date falls on the sixteenth (16th) day through the end of the month.

Substantive Eligibility Criteria (Optional): Provide a representation below regarding the terms of any eligibility conditions (other than any applicable Waiting Period already reflected above) imposed before an individual is eligible to become covered under the terms of the plan. If any of these eligibility conditions change, you are required to submit a new BPA to reflect that new information.

Check all that apply:

☐ An Orientation Period that:

1) Does not exceed one (1) month (calculated by adding one (1) calendar month and subtracting one (1) calendar day from an employee's start date); and

2) If used in conjunction with a Waiting Period, the Waiting Period begins on the first (1st) day after the orientation period.

☐ A Cumulative hours of service requirement that does not exceed 1200 hours

☐ An hours-of-service per period (or full-time status) requirement for which a measurement period is used to determine the status of variable-hour Employees, where the measurement period:

1) Starts between the Employee's date of hire and the first (1st) day of the following month;

2) Does not exceed twelve (12) months; and

3) Taken together with other eligibility conditions does not result in coverage becoming effective later than thirteen (13) months from the Employee's start date plus the number of days between a start date and the first (1st) day of the next calendar month (if start day is not the first (1st) day of the month).

☐ Other substantive eligibility criteria not described above; please describe:_____

(HMO only) What is the effective date of coverage for a Newly Eligible Employee who becomes effective after the Employer's initial enrollment date?

☐ The first (1st) day of the month following the date of employment (date of hire).

☐ The first (1st) day of the month following select one days of employment.

☐ The first (1st) day of the month following select one month(s) of employment.

☐ The date of employment (date of hire).

4. **Are there multiple new hire Waiting Periods**? ☐ Yes ☐ No

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

Is the Waiting Period requirement to be waived on initial group enrollment?

Health ☐ Yes ☐ No ☐ N/A Dental ☐ Yes ☐ No ☐ N/A

5. **Annual Open Enrollment:** For Health and Dental Plans only, an Eligible Person, who did not enroll under timely enrollment, may apply for individual coverage, family coverage or add Dependents during the Employer's annual Open Enrollment Period. Such person's individual coverage date, family coverage date and/or Dependent's coverage date will be the Policy Anniversary Date following the Open Enrollment Period, provided the application is dated and signed prior to that date.

The Open Enrollment Period will be held during a thirty-one (31) day period prior to the Policy Anniversary Date of the program. Specify start of annual Open Enrollment Period: _____

6. **The minimum standard limiting age for covered Dependent children is twenty-six (26) years.** Hereafter, a Dependent Child, Child or Children means a natural child, a stepchild, a medical support order child, an eligible foster child, an adopted child (including a child for whom the Employee or their spouse is a party in a suit in which the adoption of the child is sought) 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. To be eligible for coverage, a child of an Employee's child must also be dependent upon Employee for federal income tax purposes at the time application for coverage is made.

7. **Disabled Dependent:** Disabled Dependent means a child who is medically certified as disabled and dependent upon the Employee or his/her spouse (or Domestic Partner if Domestic Partner coverage is elected). Disabled means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. A disabled Dependent is eligible to add or continue coverage beyond the limiting age of

twenty-six (26). Certification Review is administered by BCBSTX; a Disabled Dependent Certification Form must be submitted to BCBSTX.

(HMO only) Proof of incapacity and dependency may be required within thirty-one (31) days of the child's attainment of the limiting age. Subsequent recertification may occur annually, as required.

☐ NO CHANGES CURRENT ELIGIBILITY INFORMATION

Total number of Employees/Subscribers:

1. On payroll _____
2. On COBRA continuation coverage _____
3. With retiree coverage (if applicable) _____
4. Who work part-time _____
5. Serving the new hire Waiting Period _____
6. Declining because of valid waivers including, but not limited to, other individual or group coverage, Medicare, Medicaid, TRICARE/Champus, Tribal, Risk Pool: _____
7. Declining because of non-valid waivers: _____

☐ NO CHANGES (HMO only) LEGISLATIVE ELECTIONS

The following mandated benefit offers are made by HMO in compliance with Texas regulations. Please mark your acceptance or declination. Acceptance may result in a rate adjustment.

In Vitro Fertilization Services

☐ **Accept** – If accepted, benefits for In Vitro Fertilization Services will be provided to the same extent as benefits provided for other pregnancy related procedures. **(Note: If selected, an additional charge will be added to your rates.)**

☐ **Decline** – If declined, no benefits are available

Speech and Hearing Services

☐ **Accept** – Benefits are paid same as any other illness

☐ **Decline** – If declined, medically necessary speech therapy is covered on an outpatient basis only. Hearing aid benefit is limited to one (1) hearing aid per ear every thirty-six (36) months.

Development Delay – Certain therapies for children with developmental delays are already included in the HMO plans.

☐ NO CHANGES (Non-HMO only) LEGISLATIVE ELECTIONS

The following mandated benefit offers are made in compliance with Texas regulations. The standardized Mid-Market PPO group insurance plans offered assume all benefit offers will be declined. Acceptance of either or both offers in this section will result in a rate adjustment and will require that the employer apply for coverage as a large group plan.

In Vitro Fertilization Services: Benefits for Medical-Surgical Expense incurred for in vitro fertilization procedures will be the same as for maternity care, provided specific requirements are met.

☐ **Accept** – If accepted, benefits for In Vitro Fertilization Services will be provided to the same extent as benefits provided for other pregnancy related procedures. **(Note: If selected an additional charge will be added to your rates.)**

☐ **Decline** – If declined, no benefits are available for these services.

Speech and Hearing Services: Benefits are available for the services of a physician or other provider to restore loss of or correct an impaired speech or hearing function. This benefit includes coverage for hearing aids.

☐ **Accept** – If accepted, benefits are available for medically necessary services to restore loss of or correct an impaired speech or hearing function, with no benefit maximum on hearing aids.

☐ **Decline** – If declined, benefits are available for medically necessary services to restore loss of or correct an impaired speech or hearing function; however, benefits for hearing aids are limited to one (1) hearing aid per ear every thirty-six (36) months.

Development Delay – Certain therapies for children with developmental delays are already included in the Non-HMO plans.

☐ **NO CHANGES** **LINES OF BUSINESS**
(Check all applicable products)

Managed Health Care Coverage:

☐ Single Option: PPO Plan _____

☐ Single Option: HMO* Plan _____

Additional Benefit Options:
☐ Inpatient Mental Health (IPMH): ☐ IM4
☐ Durable Medical Equipment (DME): Select DME

See HMO Legislative Elections for In-Vitro Fertilization and Speech and Hearing Services options.

One hundred percent (100%) of Eligible Employees must reside, live, or work in the service area. The HMO service area includes all counties in Texas.

***If Single Option: HMO is the only health plan selected,** complete the HMO Non-Network Plan Certification (item 1) in the OTHER PROVISIONS section of this BPA

☐ Multiple Plan Option:

Select up to six (6) plans. All plans may be PPO or HSA plans. If an HMO is selected, a PPO must also be selected.

Plan 1 _____ **Select Product**
Plan 2 _____ **Select Product**
Plan 3 _____ **Select Product**
Plan 4 _____ **Select Product**
Plan 5 _____ **Select Product**
Plan 6 _____ **Select Product**

Preferred HSA Vendor**: Select Vendor**
If HealthEquity, Inc. is selected, BCBSTX to send HSA enrollment to HealthEquity, Inc.: ☐ Yes ☐ No
Non-Preferred Vendor: _____

HCA purchased: ☐ Yes ☐ No (If yes, complete and attach a separate HCA Benefit Program Application)

Preferred FSA Vendor: **Select Vendor**
Non-Preferred Vendor: _____

Preferred Health Reimbursement Account (HRA) Vendor: **Select Vendor**
Non-Preferred Vendor: _____

An HSA must be paired with a qualified high deductible health plan (HDHP) and follow strict requirements set forth by the Internal Revenue Service (IRS). Employer Groups should seek advice from their independent tax advisor, legal counsel, or other professional counselor, to ensure their proposed benefit strategy, with respect to HSAs, FSAs, HRAs, or other benefit arrangements, does not conflict with current IRS requirements.

☐ **Blue Directions℠** If selected, the Blue Directions Addendum is attached and made part of the Policy.

ANCILLARY COVERAGE:

☐ **Life, Disability, Specified Disease, Accident, Hospital Indemnity and Vision:** If checked, attach separate application for those coverages

DENTAL BENEFIT PLANS:

Voluntary Group Dental

☐ Plan _____

☒ Dual Option: Plan 1 _____ Plan 2 _____

Employer-Paid Dental

☐ Plan _____

☐ Dual Option: Plan 1 _____ Plan 2 _____

COMMENTS: _____

RATES

For the current year's premium and rate information, refer to the accepted finalized new group rates letter ("Letter") or the renewal exhibit ("Exhibit") for complete details. The Letter, or Exhibit, shall be incorporated by reference and made part of the BPA and Group Administration Document.

HMO PROGRAM

☐ ***Yes** ☐ **No**

Account Status: ☐ New Group ☐ Existing Group

Choose One: ☐ Blue Premier℠ HMO ☐ Blue Premier Access℠ HMO

☐ Blue Essentials℠ HMO ☐ Blue Advantage HMO℠

*If an HMO product/benefit plan is selected, please complete, sign, and submit a Disclosure Statement with this BPA for Amendment.

☐ NO CHANGES CONTRIBUTION

STANDARD PREMIUM INFORMATION

1. Premium Period:

☐ The first (1st) day of each calendar month through the last day of each calendar month.

☐ The fifteenth (15th) day of each calendar month through the fourteenth (14th) day of the next calendar month.

2. The contribution of premium to be paid by the Employer is:

Product	Employee Only	Employee/Child(ren)	Employee/Spouse	Employee/Family
HEALTH				
Plan 1	% **or** $	% **or** $	% **or** $	% **or** $
Plan 2	% **or** $	% **or** $	% **or** $	% **or** $
Plan 3	% **or** $	% **or** $	% **or** $	% **or** $
Plan 4	% **or** $	% **or** $	% **or** $	% **or** $
Plan 5	% **or** $	% **or** $	% **or** $	% **or** $
Plan 6	% **or** $	% **or** $	% **or** $	% **or** $
DENTAL				
Plan 1	% **or** $	% **or** $	% **or** $	% **or** $
Plan 2	% **or** $	% **or** $	% **or** $	% **or** $

3. (HMO only) Grace Period: thirty (30) days – standard.

4. Prior written notification by BCBSTX to employer for change of premium rates is sixty (60) days

5. Additional Information/Comments: _____

☐ **NO CHANGES** **BILLING SPECIFICATIONS**

Employees Listed: ☐ alphabetically
☐ by location
If by location, list locations including location numbers if applicable: _____

Sort by: ☐ Unique Identification Number **(standard)**
☐ Social Security Number

Billing format: (complete only if special billing requirements are needed.)
☐ Benefit Agreement
☐ Also, Page Break
☐ Multiple Billing Categories
Explanation: _____

☐ **NO CHANGES** **ID CARD DELIVERY**

Mail ID Cards to:
☐ Account
☐ Member's home **(standard)**
Note: if an HMO plan is selected, HMO ID cards must be mailed to the Member's home

☐ **NO CHANGES** **OTHER PROVISIONS**

1. **Electronic Issuance**: Delivery of insurance documents, including but not limited to the GAD, BPA, Benefit Booklet, SBC and other required forms and amendments thereto, will be delivered via an electronic file or access to an electronic file to the Employer for delivery of applicable documents to each Employee. The Employer agrees that it is solely responsible for providing each Employee access to the most current version of any E-file Benefit Booklet, amendment, or other revised form provided by BCBSTX, or to provide a paper copy of the same to an Employee upon request. The Employer is solely responsible and will hold BCBSTX harmless from any misuse of the E-file provided by BCBSTX. You can request paper delivery of insurance documents by opting-out below. You may also go back to paper delivery at any time with no penalty. To change your preferences, contact your Account Executive. Your documents can be viewed or printed using your computer or mobile device that supports mobile browsing. If the method to access electronic files is revised, BCBSTX will notify you and give an opportunity to request paper delivery. Notice of cancellation or termination of a policy will be delivered both electronically and in paper form.

☐ **Opt-Out** – Employer declines to receive electronic versions of insurance documents.

2. **(HMO only) HMO Non-Network Plan Certification**: The Texas Insurance Code mandates HMOs whose network-based delivery system of coverage is the only health benefit coverage being offered under an Employer's health benefit plan must offer all Eligible Subscribers the opportunity to obtain other health coverage through a non-network plan at the time of enrollment and at least annually.

The non-network coverage required by law may be provided through a point-of-service contract, a preferred provider benefit plan, or any coverage arrangement that allows an Employee to access services outside the HMO's or limited provider network's delivery network. New and renewing groups who refuse to offer or certify that they offered a non-network plan concurrent with the HMO-only will not be allowed to purchase or renew coverage through BCBSTX. To comply with the provisions of this mandate, BCBSTX requests employer groups certify a non-network plan will be offered to Eligible Subscribers.

Describe Non-Network Product Offered: _____

Authorized Company Official's Initials: _____

3. This BPA is incorporated into and made a part of the Policy entered into and agreed upon by BCBSTX and the account.

4. Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

5. **Reimbursement:** It is understood and agreed that in the event BCBSTX makes a recovery on a third-party liability claim, BCBSTX will retain twenty-five percent (25%) of any recovered amounts, other than recovery amounts received as a result of, or associated with, any Workers' Compensation Law.

6. **Third-Party Recovery Vendors and Law Firms Provisions (other than Reimbursement Services)**: BCBSTX engages with third-party recovery vendors and law firms on a post-pay basis to identify and/or recover any potential overpayments that may have been made to Providers.

7. **Massachusetts Health Care Reform Act:** If elected below, BCBSTX will provide required written statements of Minimum Creditable Coverage ("MCC") to Participants residing in Massachusetts and submit applicable electronic reporting to the Massachusetts Department of Revenue. Information transmitted will be exclusively based on information provided to BCBSTX by Employer and coverage under the Plan(s) during the term of the Policy. By electing to have BCBSTX transmit these creditable coverage reports on Employer's behalf, Employer hereby certifies that, to the best of its knowledge, such coverage under the Plan(s) is "creditable coverage" in accordance with the Massachusetts Health Care Reform Act. Employer acknowledges that BCBSTX is not responsible for verifying nor ensuring compliance with any tax and/or legal requirements related to this service. Employer or its Participants should seek advice from their legal or tax advisors as necessary. If not elected, 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.

☐ Employer consents to BCBSTX transmitting MCC reports on its behalf. Further, Employer attests that the information submitted is true and compliant with all relevant MCC Regulations.

☐ Employer will transmit MCC reports, and any other documentation as may be required to comply with the Massachusetts Health Care Reform Act.

8. **Wellbeing Management (WBM) (included)**

9. ☐ **Medical and Ancillary Package Pricing:** The rates shown in this Policy reflect a volume-based discount in an amount up to three percent (3%) of the medical premium for the twelve (12) month period beginning on the Policy Effective Date. If any of the qualifying ancillary coverage (BlueCare Dental, Basic Life, Short-Term Disability, Long-Term Disability, Accident, Critical Illness, Hospital Indemnity and/or Vision product(s)) lapses during this twelve (12) month period, BCBSTX reserves the right to remove the volume-based discount attributable to the lapsed product on medical premium. In such event, upon sixty (60) days prior written notice to Employer, the premium payment will be adjusted to reflect the removal of the discount attributable to the lapsed product.

ADDITIONAL PROVISIONS:

A. **Grandfathered Health Plans:** Employer shall provide BCBSTX with written notice prior to renewal (and during the plan year, at least sixty (60) days advance written notice) of any changes in its Contribution Rate Based on Cost of Coverage or Contribution Rate Based on a Formula towards the cost of any tier of coverage for any class of Similarly Situated Individuals as such terms are described in the Affordable Care Act and applicable regulations. Any such changes (or failure to provide timely notice thereof) can result in retroactive and/or prospective changes by BCBSTX to the terms and conditions of coverage. In no event shall BCBSTX be responsible for any legal, tax or other ramifications related to any benefit package of any group health insurance coverage (each hereafter a "plan") qualifying as a "grandfathered health plan" under the Affordable Care Act and applicable regulations or any representation regarding any plan's past, present and future grandfathered status. The grandfathered health plan form ("Form"), if any, shall be incorporated by reference and made part of the BPA and Group Policy, and Employer represents and warrants that such Form is true, complete, and accurate. If Employer fails to timely provide BCBSTX with any requested grandfathered health plan information, BCBSTX may make retroactive and/or

prospective changes to the terms and conditions of coverage, including changes for compliance with state or federal laws or regulations or interpretations thereof.

B. **Retiree Only Plans and/or Excepted Benefits:** If the BPA includes any retiree only plans and/or excepted benefits, then Employer represents and warrants that one (1) or more such plans is not subject to some or all of the provisions of Part A (Individual and Group Market Reforms) of Title XXVII of the Public Health Service Act (and/or related provisions in the Internal Revenue Code and Employee Retirement Income Security Act) (an "exempt plan status"). Any determination that a plan does not have exempt plan status can result in retroactive and/or prospective changes by BCBSTX to the terms and conditions of coverage. In no event shall BCBSTX be responsible for any legal, tax or other ramifications related to any plan's exempt plan status or any representation regarding any plan's past, present and future exempt plan status.

C. Employer shall indemnify and hold harmless BCBSTX and its directors, officers and employees against any and all loss, liability, damages, fines, penalties, taxes, expenses (including attorneys' fees and costs) or other costs or obligations resulting from or arising out of any claims, lawsuits, demands, governmental inquiries or actions, settlements or judgments brought or asserted against BCBSTX in connection with (a) any plan's grandfathered health plan status, (b) any plan's exempt plan status, (c) any directions, actions and interpretations of the Employer, and/or (d) any provision of inaccurate information. Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

The provisions of paragraphs A-C (directly above) shall be in addition to (and do not take the place of) the other terms and conditions of coverage and/or administrative services between the parties.

Notwithstanding anything in the Policy or Renewal(s) to the contrary, BCBSTX reserves the right to revise our charge for the cost of coverage (premium or other amounts) at any time if any local, state or federal legislation, regulation, rule or guidance (or amendment or clarification thereto) is enacted or becomes effective/implemented, which would require BCBSTX to pay, submit or forward, on its own behalf or on the Policyholder's behalf, any additional tax, surcharge, fee, or other amount (all of which may be estimated, allocated or pro-rated amounts).

Renewals Only: (For the purposes of this Policy, the term "existing BPA" includes, if applicable, the initial Schedule of Specifications and/or Group Agreement signed by the Employer, and any subsequent Schedules of Specifications and/or Group Agreements and amendments thereto.) If this BPA is blank, it is intentional, and this BPA is an addendum to the existing BPA. In such case, all terms of the existing BPA as amended from time to time shall remain in force and effect. However, beginning with the Employer's first renewal date on or after September 23, 2010, the provisions of paragraphs A-C (above) shall be part of (and be in addition to) the terms of the existing BPA as amended from time to time.

EMPLOYER STATEMENTS:

1. BCBSTX reserves the right to take any or all of the following actions:

a. Initial rates for new groups will be finalized for the effective date of the policy based on the enrolled participation and Employer contribution levels;

b. After the policy effective date, the group will be required to maintain a minimum Employer contribution of fifty percent (50%), and at least a seventy-five percent (75%) participation of Eligible Employees. In the event the group is unable to maintain the contribution and participation requirements, then the rates will be adjusted accordingly; and/or

c. Non-renew or discontinue coverage if the fifty percent (50%) minimum Employer contribution is not met and/or less than seventy-five percent (75%) of Eligible Employees are enrolled for coverage for six (6) consecutive months.

BCBSTX reserves the right to change premium rates when a substantial change occurs in the number or composition of Subscribers covered. A substantial change will be deemed to have occurred when the number of Employees/Subscribers covered changes by ten percent (10%) or more over a thirty (30) day period or twenty-five percent (25%) or more over a ninety (90) day period.

Employer will promptly notify BCBSTX of any change in participation and Employer contribution.

2. Producer Statement (if applicable): I certify that I have reviewed all enrollment materials. I have also advised the Employer that I have no authority to bind these coverages, to alter the terms of the Policy(ies), this BPA or enrollment material in any manner or to adjust any claims for benefits under the Policy(ies).

3. BCBSTX will report the value of all remuneration by BCBSTX to ERISA plans with one hundred (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 one hundred (100) participants. Reporting will include base commissions, bonuses, incentives, or other forms of remuneration for which your agent/consultant is eligible for the sale or renewal of self-funded and/or insured products.

4. The undersigned person represents that he/she is authorized and responsible for purchasing coverage on behalf of the Employer. It is understood that the actual terms and conditions of coverage are those contained in the Policy into which this BPA shall be incorporated at the time of acceptance by BCBSTX. Upon acceptance, BCBSTX shall issue a Contract to the employer and the employer shall be referred to as the “Employer or Policyholder” (Non-HMO) and “Group” (HMO) in the Contract.

Authorized BCBSTX Representative	Signature of Authorized Purchaser
Title	Title
Date	Date
Agent Representative (if applicable)	

PROXY (OPTIONAL)

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC"), or any successor thereof , 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 is scheduled to be held each year in the HCSC corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice provided 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 either 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.

HCSC pays indemnification or advances expenses to its directors, officers, employees, or agents 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: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Dated this _____ day of _____ _____
Month Year

BlueCross BlueShield of Texas

Consumer Choice Plan Disclosure Statement

This health plan does not include the same level of benefits required in other plans.

This HMO plan is a consumer choice plan. This plan doesn't include the same level of benefits that are in Texas health plans known as state-mandated plans. This plan does include all health benefits required by the Affordable Care Act.

To see all benefits offered by this plan, go to the plan's "Summary of Benefits and Coverage."

Benefit/coverage:	This plan:	A health plan with required benefits (state-mandated plan):
Deductible The amount you pay for care before the plan begins to share the cost.	Has a deductible.	Has no deductibles for participating provider care.
Out-of-Pocket Costs The amount you pay when you receive covered services, up to a calendar year maximum**.**	Includes out-of-pocket costs that meet federal requirements but may sometimes be more than in a state-mandated plan.	A copay must be less than 50% of the total cost of the service. Annual out-of-pocket costs must be capped at 200% of your annual premium cost if you alert the plan.
Habilitative and Rehabilitative Care Care that helps you improve skills for daily living.	Includes a limit on the number of visits per year for speech therapy, occupational therapy, physical therapy and chiropractic care. Limits do not apply for the treatment of acquired brain injury and autism spectrum disorder.	Has no limits on the amount of care if it is needed for medical reasons.
Home Health Services	Includes a limit for home health services.	Has no limits on home health services.
Therapies for Children with Developmental Delays	Does not cover therapies for treatment of developmental delay in children	Covers certain development delay therapies for children with developmental delay, up to age three.

BlueCross BlueShield
of Texas

If you want a plan with all required benefits:

We also offer a state-mandated plan that includes all required benefits. This plan is not on Healthcare.gov and does not allow you to get help with premiums and out-of-pocket costs. To learn more about this plan, call 1-877-299-2377or visit https://www.bcbstx.com/shop-plans-and-products.

By signing this form, you acknowledge the following:

- I understand the consumer choice plan I am applying for does not provide the same level of coverage required in other Texas health plans (state-mandated plans).
- I understand I can get more information about consumer choice plans from the Texas Department of Insurance's website, https://www.tdi.texas.gov/consumer/consumerchoice.html, or by calling the Consumer Help Line at 1-800-252-3439.

Do not sign this document if you don't understand it.
No firme este documento si no lo comprende.

_____ _____
Signature of Applicant **Date**

_____
Name of Applicant (print name)

_____
Name of Business, if applicable

_____
Address

_____ _____
City **State** **Zip**

HMO must give you a copy of this statement upon request.