BlueCross BlueShield of Texas

SMALL EMPLOYER BENEFIT PROGRAM APPLICATION
("Employer Application")

(The following information only applies if selecting a Consumer Choice plan)
You have the option to choose a Consumer Choice of Benefits Health Maintenance Organization (HMO) health care plan that, either in whole or in part, does not provide state-mandated health benefits normally required in evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage (Certificate of Coverage).

Application is hereby made to Blue Cross and Blue Shield of Texas,
a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("BCBSTX")

Legal Name of Company:		
Employer Identification Number (EIN):	Nature of Business:	Standard Industry Code (SIC):
Physical Address (number & street), City, State, ZIP:		
E-Mail Address of Authorized Company Official:		Telephone Number:
Secondary E-Mail Address, if different from Authorized Company Official:		FAX Number:
Complete Mailing Address, if different from physical address:		
Billing and Correspondence to the attention of:		
Billing Method Selection: Please select one (1) of the following billing methods. ☐ Composite Billing ☐ Age Billing		
The Blue Access for Employers℠ ("BAE℠") contact person is the individual authorized by the Employer to access and maintain its account/employee information. Name and title of the BAE contact person: _____ E-mail address of BAE contact person: _____		
Requested Contract(s)/Policy(ies) Effective Date (first (1st) or fifteenth (15th)): _____/_____/_____ (mm/dd/yyyy)		

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.

Please provide your ERISA Plan Year* (mm/dd/yyyy): Beginning Date:__/__/_____ End Date:__/__/_____

ERISA Plan Sponsor*: _____

If you maintain that ERISA is not applicable to your account, please give the 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 (complete and attach a Medical Loss Ratio Assurance form)
☐ Other; please specify: _____

Please provide Non-ERISA Plan Year (mm/dd/yyyy): _____/_____/_____

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

A copy of your most recent Texas Workforce Commission (TWC) Report(s) or other supporting documentation must be submitted with this Employer Application (please identify part-time Employees and terminations). W4s, 1099s, or a Texas Supplemental Employment Verification form must be submitted for any applicants not included on the TWC Report.

1. **Select a Waiting Period:** 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 BCBSTX, BCBSTX reserves the right to retroactively adjust the coverage date for such person.

a. Newly eligible individuals will become effective on the first (1st) or fifteenth (15th) day of the contract/participation month following: ☐ Zero (0) days ☐ Thirty (30) days ☐ Sixty (60) days.

Employee and dependent Health and/or Dental Benefit Plans will become effective on the first (1st) day of the contract/participation month following satisfaction of the Waiting Period and any substantive eligibility criteria.

b. Waive the Waiting Period on initial group enrollment? ☐ Yes ☐ No

c. Number of Employees serving Waiting Period: _____

d. Substantive eligibility criteria: 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. In no event can the substantive eligibility criteria result in a delay of coverage for eligible Employees, as defined under Texas law, longer than ninety (90) days inclusive of the Waiting Period. 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).

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

2. Total number of enrollment applications submitted: _____ Total number of declinations submitted: _____

3. Do all Employees reside in Texas? ☐ Yes ☐ No
If no, is Texas the state with the greatest number of Employees eligible to enroll in this group plan? ☐ Yes ☐ No

4. Is the company headquartered in Texas? ☐ Yes ☐ No

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 Contract Anniversary Date following the Open Enrollment Period, provided the application is dated and signed prior to that date.

Enrollment period will be held thirty-one (31) days prior to the Contract Anniversary Date of the program.

6. **Domestic Partners covered:** ☐ Yes ☐ No
If yes, a Domestic Partner, as defined in the Certificate Booklet, shall be considered eligible for coverage. The Employer is responsible for providing notice of possible tax implications to those covered Employees with Domestic Partners.

Continuation coverage for Domestic Partners: If Employer elects coverage for Domestic Partners, Domestic Partners may be eligible for continuation coverage under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Employer shall determine eligibility for COBRA continuation for Domestic Partners, if any. Please indicate your election below:

☐ Yes, Employer elects to offer continuation coverage to Domestic Partners, as defined in the Certificate Booklet

☐ No, Employer does not elect to offer continuation coverage to Domestic Partners (Domestic Partners are not eligible for continuation coverage)

☐ Other: _____

7. Dependent children are eligible for coverage until their twenty-sixth (26th) birthday. Dependent Child, used hereafter, means a natural child, a stepchild, an eligible foster child, a medical or dental support order child, an adopted child or child placed for adoption (including a child for whom the Employee or his/her spouse, or Domestic Partner, if Domestic Partner coverage is elected, is a party in a legal action in which the adoption of the child is sought), under twenty-six (26) years of age, 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. A child not listed above who is legally and financially dependent upon the Employee or spouse (or Domestic Partner, if Domestic Partner coverage is elected) is also considered a Dependent child under the Group Health Plan, provided proof of dependency is provided with the child's application. 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.

8. **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). 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. 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.

9. Are you an independent school district that is a large employer electing to participate as a small employer? ☐ Yes ☐ No

10. Will you have been without group coverage (uninsured) for at least two (2) months prior to the requested Contract(s)/Policy(ies) effective date of coverage?
☐ Yes ☐ No

11. If you currently have group health care coverage, complete the following:

a. Present health carrier's name _____

b. Paid-to-date with current carrier: _____/_____/_____ (mm/dd/yyyy)

c. Calendar year medical deductible amount with current carrier: Individual: _____ Family: _____

LEGISLATIVE REQUIREMENTS

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

THE FOLLOWING MANDATED BENEFIT OFFERS ARE ALREADY INCLUDED IN THE PPO AND HMO PLANS

- Treatment of mental or emotional illness
- Treatment of loss or impairment of speech or hearing
- Treatment of serious mental illness
- Treatment of home health care (PPO only)

MANDATED BENEFIT OFFERS

In Vitro Fertilization Services - (must choose one (1))

☐ Accept – Outpatient benefits are paid same as any other pregnancy-related expense **(Note: If selected an additional charge will be added to your rates.)**

☐ Decline – If declined, no benefits are available

BENEFIT PLAN SELECTIONS

Select **UP TO SIX (6)** medical plans to offer.

If HSA/HDHP is selected, provide name of HSA administrator/trustee: _____
Vendor: ☐ BenefitWallet ☐ Flex ☐ HealthEquity ☐ HSA Bank ☐ Other: _____

FSA purchased: ☐ Yes ☐ No (If yes, select vendor)
Vendor: ☐ BenefitWallet ☐ Flex ☐ HealthEquity ☐ HSA Bank ☐ Other: _____

Metallic Levels	Blue Choice PPO℠ (select up to 6)		*Blue Advantage HMO℠ (select up to 6)	
		Plan ID		**Plan ID**
BRONZE PLANS	☐	B660CHC	☐	B660ADT
	☐	B661CHC	☐	B661ADT
	☐	B662CHC	☐	B9E1ADT
SILVER PLANS	☐	S660CHC	☐	S640ADT
	☐	S661CHC	☐	S641ADT
	☐	S662CHC	☐	S642ADT
	☐	S663CHC	☐	S643ADT
	☐	S665CHC	☐	S644ADT
	☐	S666CHC	☐	S9E1ADT
	☐	S667CHC	☐	S9E3ADT
	☐	S9K1CHC	☐	S9E5ADT
	☐	S9L3CHC	☐	S9J3ADT
	☐	S9L5CHC	☐	S9J5ADT
	☐	S9L7CHC	☐	S9J7ADT
	☐	S9L9CHC	☐	S9J9ADT
	☐	S9M2CHC	☐	S9K2ADT
	☐	S9M4CHC	☐	S9L1ADT
GOLD PLANS	☐	G650CHC	☐	G660ADT
	☐	G651CHC	☐	G661ADT
	☐	G652CHC	☐	G662ADT
	☐	G653CHC	☐	G663ADT
	☐	G654CHC	☐	G664ADT
	☐	G656CHC	☐	G665ADT
	☐	G9K4CHC	☐	G666ADT
	☐	G9K6CHC	☐	G9E1ADT
	☐	G9K8CHC	☐	G9E3ADT
	☐	G9L1CHC	☐	G9E5ADT
	☐	G9L5CHC	☐	G9J1ADT
	☐	G9L7CHC	☐	G9K5ADT
			☐	G9K7ADT
PLATINUM PLANS	☐	P620CHC	☐	P610ADT
	☐	P621CHC	☐	P611ADT
	☐	P9K3CHC	☐	P9K3ADT
	☐	P9M1CHC	☐	P9M1ADT

*****If a Blue Advantage HMO product/benefit plan (with the **exception** of G665ADT plan) is selected, please complete, sign and submit a Disclosure Statement with this Application for Amendment.

Additional Information: _____

DENTAL PRODUCTS/BENEFIT PLAN SELECTION:

Plan Pairings
Groups with two (2) to nine (9) enrollees may select one (1) plan. Groups with ten (10)+ enrollees may select up to two (2) plans.

Contributory
Any one (1) contributory high option can be paired with any one (1) contributory low option; DTXHM41 can be freely paired with any contributory option**.**

Voluntary
Any one (1) voluntary high option can be paired with any one (1) voluntary low option. DTXHM45 can be freely paired with any one (1) voluntary option.

Voluntary plans and contributory plans may not be offered together.

Exception: DTXHM57 can be paired with DTXHR33. And, DTXHM59 can be paired with DTXHR42.

Participation Requirements

Contributory
> seventy-five percent (75%) participation
> fifty percent (50%) employer contribution

Voluntary
> twenty-five percent (25%) participation

Employers are not required to contribute to Voluntary Dental plans.

DENTAL PLAN SELECTION

	Plan #	Segment
	High Coverage Allocation	
☐	DTXHR30	Contributory
☐	DTXHR31	Contributory
☐	DTXHR32	Contributory
☐	DTXHR33	Contributory
☐	DTXHR34	Contributory
☐	DTXHM39	Contributory
☐	DTXHM41	Contributory
☐	DTXHR50	Contributory
☐	DTXHM57	Contributory
☐	DTXHR42	Voluntary
☐	DTXHM43	Voluntary
☐	DTXHM45	Voluntary
☐	DTXHR51	Voluntary
☐	DTXHR52	Voluntary
☐	DTXHM59	Voluntary
	Low Coverage Allocation	
☐	DTXLR35	Contributory
☐	DTXLR36	Contributory
☐	DTXLR37	Contributory
☐	DTXLM38	Contributory
☐	DTXLM40	Contributory
☐	DTXLM44	Contributory
☐	DTXLR58	Contributory
☐	DTXLR46	Voluntary
☐	DTXLM49	Voluntary
☐	DTXLR53	Voluntary
☐	DTXLM54	Voluntary
☐	DTXLR60	Voluntary

The Employer understands and agrees to comply with the following requirements regarding the Health Benefit Plan(s) elected:

1. Applications/Declinations are attached for all full-time Employees as well as any COBRA or state participant continuations.

2. **Minimum Participation and Employer Contribution.** BCBSTX reserves the right to:

a. Restrict new business enrollment in health insurance coverage to open or special enrollment periods unless the fifty percent (50%) minimum Employer contribution is met and at least seventy-five percent (75%) of eligible Employees (less valid waivers) have enrolled for coverage; and

b. Review participation and contribution on existing business and non-renew or discontinue health coverage if the fifty percent (50%) minimum Employer contribution is not met and/or less than seventy-five percent (75%) of Eligible Persons (less valid waivers) are enrolled for coverage for six (6) consecutive months.

If applicable, 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.

3. The Employer must provide eligibility and enrollment information, effective dates of employment, and all other data necessary for the efficient administration of the Health Benefit Plan(s) elected, according to the terms and requests of BCBSTX.

4. After approval by BCBSTX the Health and/or Dental Benefit Plan(s) applied for, individuals will become effective on the first (1st) day of the contract/participation month following satisfaction of the Waiting Period (if any, but not to exceed ninety (90) days). Employees whose applications are received more than thirty-one (31) days after date-of-hire or received after expiration of the Waiting Period will be considered late enrollees and will be eligible to enroll during the next open enrollment period.

5. The Employer, while not an agent of BCBSTX, will be responsible for collection of premiums from Employees, will notify Employees of the termination of their coverages and will forward to Employees notices and/or amendments sent by BCBSTX to the Employer. The Employer will be bound by the terms of the Contract(s)/Policy(ies) issued pursuant to this Employer Application and such shall serve as the basis to resolve any conflict. When issued, the Contract(s)/Policy(ies) will include this Employer Application and any Addenda issued pursuant to this Employer Application.

6. Premium rates for the coverages applied for are determined by BCBSTX and will become a part of the Contract(s)/Policy(ies) issued by BCBSTX and any amendments thereto.

7. This Employer Application must pre-date the requested effective date and be received by BCBSTX at its home office no less than thirty (30) days prior to the requested effective date.

8. Retirees are not eligible for coverage hereunder.

9. Under Texas state law, ***eligible employee*** means an employee who works on a full-time basis and who usually works at least thirty (30) hours a week. 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 small 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 other eligible employees who work on a full-time basis and who usually work at least thirty (30) hours a week. The term does not include an Employee who: (1) works on a part-time, temporary, seasonal, or substitute basis, or (2) is covered under (a) another Health Benefit Plan, or (b) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974, or (3) elects not to be covered under the small employer's health benefit plan and is covered under (a) the Medicaid program; (b) another federal program, including the TRICARE program or Medicare program; or (c) a benefit plan established in another country.

10. The producer(s) or agency(ies), specified in the Producer's Statement section below, is/are recognized as Employer's Producer of Record (POR) to act as representative in negotiations with and to receive commissions from BCBSTX and HCSC subsidiaries for Employer's employee benefit programs. 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.

11. 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.

Application is hereby made for a Life Insurance Plan (including Term Life Insurance, Accidental Death and Dismemberment (AD&D), Dependents' Life, Supplemental Life, Short-Term Disability (STD), Long-Term Disability (LTD), Specified Disease, Accident, and/or Vision

I. Group Life Administration Information

Eligibility: ☐ All active Employees ☐ All active Employees enrolled for health insurance who work a minimum of thirty (30) hours per week excluding seasonal, temporary, or retired Employees

Benefit: All Employees according to the following schedule:

Class	Job Title, as shown on the enrollment form	Life & AD&D Benefit Amount	STD Amount (if elected)
1			
2			
3			

	Term Life/AD&D	Dependents' Life	STD
Total eligible Employees: _____			
Total enrolling: _____			

Contract Anniversary Date: ☐ twelve (12) months from Contract Effective Date ☐ Other _____

II. Term Life Insurance and AD&D: ☐ Applied For ☐ Not Applied For

Complete Life and AD&D Benefit Amount in Section I	Guarantee Issue Maximum: $ _____
Rates: ☐ Step-Rated ☐ Composite Rated	(Include a copy of the rating exhibit if rated in the field)
Employer Contribution: ☐ One hundred percent (100%) ☐ Other _____% (Minimum Twenty-five percent (25%) Employer contribution required)	

Life/AD&D Reductions due to Attained Age (All benefits terminate at retirement):

- ☐ Reduces by thirty-five percent (35%) at age sixty-five (65), to fifty percent (50%) of the original benefit at age seventy (70), to twenty-five percent (25%) of the original benefit at age seventy-five (75), and to fifteen (15%) of the original benefit at age eighty (80). (Standard under ten (10) eligible lives)
- ☐ Reduces by thirty-five percent (35%) at age sixty-five (65) and to fifty percent (50%) of the original benefit at age seventy (70). (Unavailable under ten (10) eligible lives)
- ☐ Reduces to fifty percent (50%) at age seventy (70). (Unavailable under ten (10) eligible lives)

Term Life is: ☐ in addition to, or ☐ replacement of current term life coverage ☐ no current carrier

If replacement, give current carrier: _____ Termination date of prior plan: _____

III. Dependents' Term Life Insurance: ☐ Applied For (offered only with Term Life/AD&D) ☐ Not Applied For

Benefits: _____	Spouse: $ _____
Rate: $ _____	Child(ren) Live birth up to six (6) months: $ _____
Employer Contribution: _____ %	Child(ren) age six (6) months up to age twenty-six (26) & Students: $ _____

IV. Short Term Disability (STD) Insurance: ☐ Applied For (offered only with Term Life/AD&D) ☐ Not Applied For

Wage-Based Benefit: ☐ Fifty percent (50%) ☐ Sixty percent (60%) ☐ Sixty-six and two-thirds percent (66 2/3%) of Basic Weekly Wages to a Benefit Maximum of $ _____

Flat Benefit: ☐ Fifty dollars ($50) ☐ One hundred dollars ($100) ☐ One hundred fifty dollars ($150) ☐ Two hundred dollars ($200) ☐ Two hundred fifty dollars ($250) not to exceed sixty-six and two-thirds percent (66 2/3%) of Basic Weekly Wages

Class Defined Plan: Complete STD amount in Section I

Benefits Begin:

Due to an Accident: (select one)
- ☐ First (1st) day
- ☐ Eighth (8th) day
- ☐ Fifteenth (15th) day
- ☐ Thirty-first (31st) day

Due to Sickness: (select one)
- ☐ Eighth (8th) day
- ☐ Fifteenth (15th) day
- ☐ Thirty-first (31st) day

Maximum Weekly Benefit Duration: ☐ Thirteen (13) weeks ☐ Twenty-six (26 weeks)
Rates: ☐ Step-Rated ☐ Composite Rated (Include a copy of the rating exhibit if rated in the field)
Employer Contribution: ☐ One hundred percent (100%) ☐ Other _____% (Minimum twenty-five percent (25%) Employer contribution required)
STD is: ☐ in addition to, or ☐ replacement of current STD coverage ☐ no current STD carrier If replacement, give current carrier: _____ Termination date of prior plan: _____ STD benefits are payable for non-occupational disabilities only. STD benefits terminate at retirement.

V. Supplemental Life Insurance:

☐ **No change** ☐ **New Coverage Applied For** ☐ **Upgrade** ☐ **Other (explain)**

Benefit Plan: _____ Employer Contribution _____%

VI. Long-Term Disability Insurance:

☐ **No change** ☐ **New Coverage Applied For** ☐ **Upgrade** ☐ **Other (explain)**

Benefit Plan: _____ Employer Contribution _____%

VII. Specific Disease Insurance:

☐ **No change** ☐ **New Coverage Applied For** ☐ **Upgrade** ☐ **Other (explain)**

Benefit Plan: _____ Employer Contribution _____%

VIII. Accident Insurance:

☐ **No change** ☐ **New Coverage Applied For** ☐ **Upgrade** ☐ **Other (explain)**

Benefit Plan: _____ Employer Contribution _____%

IX. Vision Insurance:

☐ **No change** ☐ **New Coverage Applied For** ☐ **Upgrade** ☐ **Other (explain)**

Benefit Plan: _____ Employer Contribution _____%

The undersigned represents he/she is an Employer engaged in (groups with two (2) to nine (9) Employees must check ✓ one (1)): ☐ Wholesale, Retail, or Distribution Business; or ☐ Service Business; or ☐ Manufacturing Business

The Employer agrees to comply with all terms and provisions of the Group Life, Disability, Specified Disease, Accident, and/or Vision Contract(s) issued. The Employer further agrees to comply with the following requirements:

1. If coverage is contributory, a minimum of seventy-five percent (75%) of the eligible Employees must enroll. If coverage is non-contributory, one hundred percent (100%) of the eligible Employees must enroll.

2. Group term life, for groups with less than ten (10) eligible Employees, may be sold on a contributory basis, however, in no event may the contribution by the insured Employee exceed forty cents ($0.40) per thousand dollars of coverage per month.

3. STD may be sold on a contributory basis; however, the Employer must contribute a minimum of twenty-five percent (25%). STD is available only if group term life and AD&D is selected.

4. Coverage for Employees who are not actively at work, as defined in the policy, on the date their coverage would otherwise become effective will be deferred until the date they return to active work.

5. If life and AD&D benefits are selected by occupational class, there must be at least one (1) eligible Employee in each class, and no class may have a benefit greater than 2½ times the amount for the next lower class.

6. The Employer shall remit all required premium payments no later than the first (1st) day of each billing period. If the premium payments are not received, insurance for the Employer and all covered Employees shall cease in accordance with the terms of the Policy.

7. The Employer shall provide eligibility and enrollment information, dates of employment, and all other data necessary for the efficient administration of the Insurance Plan(s).

8. Coverage for the Employer may be amended from time to time, and the Employer's participation may be terminated with thirty-one (31) days written notice in accordance with the terms of the Policy. Premium rates may change for reasons including, but not limited to, change in benefit design or Policy terms, change of industry, utilization within the industry, or other factors bearing on the assumed risk.

9. The Employer's participation in the Insurance Plan(s) may terminate if the Employer fails to maintain compliance with the requirements set forth herein.

10. Benefit amounts in excess of the guarantee issue and all late applications for contributory coverage are subject to satisfactory evidence of insurability. The Employer agrees not to collect any premium from Employees on amounts for which satisfactory evidence of insurability is required until notified of the approval of the Employee's application for coverage.

EMPLOYER: DO NOT CANCEL CURRENT COVERAGE UNTIL NOTIFIED BY BCBSTX THAT THIS EMPLOYER APPLICATION HAS BEEN APPROVED.

EMPLOYER STATEMENTS:

I have read and understand this Employer's Application, and the producer, if any, named below is authorized to represent the Employer in the purchase of the Benefit Plan(s). This Employer Application is incorporated into and made a part of the Contract entered into and agreed upon by BCBSTX and the Employer. For HMO, the title of the contract is HMO Group Agreement. For non-HMO, the title of the contract is Group Administration Document. For dental, the title of the contract is Dental Group Administration Document.

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

I acknowledge that the producer(s) or agency(ies) named on the producer's Statement page is/are is acting on behalf of the Employer for purposes of purchasing Employer insurance, and that if BCBSTX accepts this Employer Application and issues a Group Contract/Policy/Agreement to the Employer, BCBSTX may pay the producer(s)/agency(ies) a commission and/or other compensation in connection with the issuance of such Group Contract/Policy. The undersigned further acknowledges that if the Employer desires additional information regarding any commissions or other compensation paid the producer(s)/agency(ies) by BCBSTX in connection with the issuance of a Group Contract/Policy, they should contact the producer(s)/agency(ies).

I certify that all statements contained in this Employer Application and all information required to be furnished to BCBSTX is complete and true to the best of my knowledge and belief. I understand that BCBSTX will rely on the statements made and information furnished, as the basis in determining the appropriate rate level and/or approval of this Employer Application. I understand that no insurance or changes will become effective without approval of BCBSTX. The requested Contract(s)/Policy(ies) effective date (as listed on page 1) is subject to change by BCBSTX if all required documents are not completed and received by the date requested. If documents are not received by the date requested, the Employer will be required to complete a new Employer Application.

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 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 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. 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 exempt status, (b) any plan's design (including but not limited to any directions, actions and interpretations of the Policyholder), and/or (c) any provision of inaccurate information. Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

C. **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.

D. **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.

The provisions of paragraphs A-D (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).

For Employer:

Name of Authorized Company Official (please print)	**Title**
Signature of Authorized Company Official	**City and State of signing official**
Date	

PRODUCER'S STATEMENT
TO BE COMPLETED BY PRODUCER(S) – PLEASE PRINT

PRODUCERS

I certify that I have reviewed all enrollment materials and I have advised the Employer not to terminate any existing coverage(s) until receiving notice that BCBSTX has accepted and approved this Employer Application. I have advised the Employer of its rights as a small group employer to purchase the **HMO** Blue Advantage Benefits Plans. I have also advised the Employer that I have no authority to bind these coverages, to alter the terms of the Contract(s)/Policy(ies), this Employer Application, or enrollment material in any manner or to adjust any claims for benefits under the Contract(s)/Policy(ies).

Writing **Producer's** name (please print): _____ E-mail Address: _____

_____ _____ _____ _____
Writing **Producer's** Signature **Producer** # Date Telephone #

_____ _____
BCBSTX Sales Representative Date

1. Primary **Producer's** or Agency Name* (to whom commissions are to be paid): _____
(Please also use #2 below, for split commissions)

Producer #: _____ Percentage of Split**: _____

Complete Address: _____ FAX #: _____

Name and phone # of agent to contact for this case: _____

Contact's E-mail address (please print clearly): _____

2. **Producer's** or Agency Name* (if commissions are to be split): _____

Producer #: _____ Percentage of Split**: _____

Street, City, ZIP: _____ FAX #: _____

Contact's E-mail address (please print clearly): _____

3. General Agent Name (if applicable): _____

Producer #: _____ FAX #: _____

Street, City, ZIP: _____

Contact name and telephone # for this case: _____

Contact's E-mail address (please print clearly): _____

General Agent's Signature: _____

*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 to be split, please provide the information requested above on both **Producers or agencies. **Both Producers** or agencies must be appointed to do business with BCBSTX, and total commissions paid must equal one hundred percent (100%).

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(s).: _____ 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.

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 1-877-299-2377 or 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.

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

BlueCross BlueShield of Texas

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.