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

BENEFIT PROGRAM APPLICATION ("BPA")

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (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)

☐ 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: _____

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: _____ Subsidiary Address:

City: _____ State: _____ Zip: _____ Contact: _____

Title: _____ Phone: _____ Fax: _____ Email: _____

Affiliated Companies to be covered: Locations:

*Mid-Market Group Plans receive the same benefits as those required for large employer plans.

ERISA Regulated Group Health* Plan: ☐ Yes ☐ No

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

If no, 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, 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 (complete and attach a Medical Loss Ratio Assurance form)
☐ Other; please specify: _____

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

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

For more information regarding ERISA, contact your Legal Advisor.

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

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

☐ 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

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
   If commission split, designate percentage for each producer/agency.
   Note: total commissions paid must equal 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 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 other Eligible Employees who work on a full-time basis and who usually work at least 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.

Are Domestic Partners eligible for continued coverage equivalent to COBRA continuation? ☐ Yes ☐ No

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 1st or 15th) of the month following the date of employment.
☐ The _____ day (standard is 1st or 15th) of the month following _____ days (select 0, 30 or 60 days) of employment.
☐ The _____ day (standard is 1st or 15th) of the month following _____ month(s) (select 1 or 2 months) of employment.

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 month (calculated by adding one calendar month and subtracting one 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 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 day of the following month;
2) Does not exceed 12 months; and
3) Taken together with other eligibility conditions does not result in coverage becoming effective later than 13 months from the Employee's start date plus the number of days between a start date and the first day of the next calendar month (if start day is not the first 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 1st day of the month following the date of employment (date of hire).
☐ The 1st day of the month following _____ days (select 0, 30 or 60 days) of employment.
☐ The 1st day of the month following _____ month(s) (select 1 or 2 months) of employment.

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.

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

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**: A 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).

   To administer medical certification of disabled Dependents, you may select option (a) Standard Rules or (b) Custom Rules. If (b) is selected there are additional selections regarding certification review, forms, and previous medical certification approvals.

   (a) ☐ Disabled Dependent Administration will follow **Standard Rules.**

   A disabled Dependent is eligible to add or continue coverage beyond the limiting age of 26. Administration of Certification Review is handled by BCBSTX; a Disabled Dependent Certification Form must be submitted to BCBSTX.

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

   (b) ☐ Disabled Dependent Administration will follow **Custom Rules**. Please make the following sections:

   Age: A disabled Dependent is eligible to add or continue coverage beyond the limiting age of 26

   Certification Review: Please select one option regarding handling of Certification Review.

   ☐ Certification Review is handled by BCBSTX; a Disabled Dependent Certification Form must be submitted to BCBSTX.

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

   ☐ Certification Review is handled by the Employer; there are no Disabled Dependent Certification Form requirements.

   If Certification Review is selected as handled by BCBSTX, please select one option regarding forms:

   ☐ The Disabled Dependent Certification Form will be utilized.

   ☐ A ☐ Custom or ☐ Other Disabled Dependent Certification Form will be utilized

   If Certification Review is selected as handled by BCBSTX, please select allowed or not allowed below:
   A disabled Dependent approved medical certification from a prior carrier is ☐ allowed ☐ not allowed.
   A disabled Dependent approved medical certification from a prior BCBS policy is ☐ allowed ☐ not allowed.

☐ 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 1 hearing aid per ear every 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 a 1 hearing aid per ear every 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:
Plan _____

☐ Dual Option:
Select two plans. Both may be PPO or HSA plans. If HMO is selected, a PPO must also be selected.
Plan 1_____ Select Product
Plan 2_____ Select Product

☐ Triple Option:
Select three plans. All three may be PPO or HSA plans. If HMO is selected, a PPO must also be selected.
Plan 1_____ Select Product
Plan 2_____ Select Product
Plan 3_____ Select Product

If a BlueEdge HSA℠ Plan is selected, provide name of HSA administrator or trustee: _____
(Vendor: **Select Vendor**)

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

DENTAL BENEFIT PLANS:_____

☐ 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.

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

***If only HMO health plan selected, please complete the HMO Non-Network Plan Certification (item 2) in the OTHER PROVISIONS section of this BPA.**

Voluntary Group Dental
☐ Plan _____
☐ Dual Option: Plan 1 _____ Plan 2 _____
☐ **Life & Disability** (if checked, attach separate application for those coverages)

COMMENTS: _____

☐ **NO CHANGES** **ACCOUNT EXPERIENCE – NEW GROUPS ONLY**

Questions 1 & 2: use $10,000 for 51-100 Employees or $20,000 for 100 or more Employees.

1. Has any Participant received more than $_____ in medical benefits during the last 12 months? ☐ Yes ☐ No
2. Is any Participant expected to have claims in excess of $_____ during the next 12 months? ☐ Yes ☐ No
3. Is any Participant mentally or physically handicapped or disabled or not actively at work? ☐ Yes ☐ No
4. Has any Participant been diagnosed as having a high-risk condition? ☐ Yes ☐ No

If any question is answered "yes," details must be provided below:

Participant Age	Diagnosis or Nature of the Disorder	Dates of Treatment	$ Amount of Claims	Prognosis/Current Treatment

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

a) Physician Service Charges:

_____% of Claim Payments; $_____ per enrollee per month for health Claim Payments; **or** ☐ N/A

b) Service Fees:

$_____ per month per single enrollee; $_____ per month per enrollee with one or more Dependents; **or** ☐ N/A

Provider Table(s): _____

c) HMO Managed Care Fee:

$_____ per HMO enrollee per month **or** ☐ N/A

☐ NO CHANGES CONTRIBUTION

STANDARD PREMIUM INFORMATION

1. Premium Period:

   ☐ The first day of each calendar month through the last day of each calendar month.
   ☐ The 15th day of each calendar month through the 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** $
DENTAL				
Plan 1	% **or** $	% **or** $	% **or** $	% **or** $
Plan 2	% **or** $	% **or** $	% **or** $	% **or** $

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

4. Prior written notification by BCBSTX to employer for change of premium rates is 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 homes (standard)

☐ NO CHANGES OTHER PROVISIONS

1. **(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: _____

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

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

4. **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.

5. **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.

6. **Wellbeing Management (included):** The undersigned representative authorizes the provision of alternative benefits rendered to Covered Persons in accordance with the provisions of the Policy.

ADDITIONAL PROVISIONS:

A. **Grandfathered Health Plans: Employer shall provide BCBSTX with written notice prior to renewal (and during the plan year, at least 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. **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 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.

I UNDERSTAND AND AGREE THAT:

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 50%, and at least a 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 50% minimum Employer contribution is not met and/or less than 75% of Eligible Employees are enrolled for coverage for six 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 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 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 Policy to the employer and the employer shall be referred to as the “Employer or Policyholder” (Non-HMO) and “Group” (HMO) in the Policy.

5. The Employer’s Benefit Program Application must pre-date the requested effective date and be received at BCBSTX at its Home Office no less than thirty (30) days prior to the requested effective date.

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, 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 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 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked either in writing by the undersigned at least 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

TEXAS DEPARTMENT OF INSURANCE
REQUIRED DISCLOSURE STATEMENT FOR ALL CONSUMER CHOICE BENEFIT PLANS ISSUED IN TEXAS

Under Texas law, HMOs are permitted to market "Consumer Choice" plans, which do not have to comply with one or more state coverage requirements. They must also offer a plan that does comply with all state requirements. HMOs are required by law to obtain signatures of consumers showing they have been given this choice.

I have been informed that the consumer choice plan that I am being offered does not include all of the health benefits usually required by Texas law. I understand that the following benefits are either excluded from the plan or provided at a reduced level:

Description of the State Requirements Reduced or Excluded	Benefit Reduced	Benefit Excluded
Copayments Section 11.506(2)(A), Subchapter F, Title 28 Texas Insurance Code: A reasonable copayment option may not exceed 50 percent of the total cost of services provided. A basic health care service HMO may not impose copayment charges on any enrollee in any calendar year, when the copayments made by the enrolled in that calendar year total 200 percent of the total annual premium cost which is required to be paid by or on behalf of that enrollee. The limitation only applies if the enrollee demonstrates that copayments in that amount have been paid that year.	For some services and supplies, this plan may include cost-sharing that exceeds the limits imposed by the mandated.	
Deductibles Section 11.506(2)(B), Subchapter F, Title 28 Texas Insurance Code: A deductible must be for specific dollar amount of the cost of the basic, limited or single health care service. Except for a consumer choice benefit plan, an HMO may not charge a deductible for services received in the HMO's delivery network, except in cases involving emergency care and services that are not available in the HMO's delivery network.	Deductibles may apply to some services provided by HMO Participating Providers in the HMO service area. Deductibles may apply to Professional Services, Inpatient Hospital Services, Outpatient Facility Services, Outpatient Lab and X-Ray Services, Rehabilitation Services, Maternity Care and Family Planning, Behavioral Health Services, Emergency and Ambulance Services, Extended Care Services, some Preventive Care Services, Dental Surgical Procedures, Cosmetic, Reconstructive or Plastic Surgery, Allergy Care, Diabetes Care, Prosthetic Appliances, Orthotic Devices, Durable Medical Equipment, Hearing Aids and Prescription Drugs.	

BlueCross BlueShield of Texas

I understand that I may get more information about consumer choice plans from the Texas Department of Insurance (TDI) by visiting the TDI website at http://tdi.texas.gov/consumer/consumerchoice.html or by calling the TDI Consumer Help Line at 1-800-252-3439.

Signature of Applicant **Name of Applicant (print name)**

Name of Business (if applicable)

Address

City **State** **Zip**

Date

Note: The HMO issuing the policy must keep this disclosure statement and provide it to the commissioner of Insurance on request. **You have the right to a copy of this written disclosure free of charge.** You must sign a new disclosure statement when you buy a consumer choice plan.