BlueCross BlueShield of New Mexico

SMALL EMPLOYER BENEFIT PROGRAM APPLICATION ("BPA")
(Application for Amendment)

Current Legal Name of Employer Group: _____
Account/Group Number: _____
Requested Effective Date of Change (1st or 15th):_____/_____/_____ Month Day Year

ONLY COMPLETE ITEMS CHANGING

Legal Name of Employer Group changing to: _____		
Request to change Anniversary Date: (1st or 15th):_____/_____ Month Day		
Employer Identification Number (EIN): _____	Fax Number: _____	Company Telephone Number: _____
Physical Address : Number, Street, City, State, Zip _____		
Mailing Address : Number, Street, City, State, Zip _____		
E-Mail Address of Authorized Company Official: _____		
Billing Address (if different from mailing): Number, Street, City, State, Zip _____		
Billing and Correspondence to the attention of: _____		Standard Industry Code ("SIC"): _____

Billing Cycle:

☐ Change billing cycle to the first day of each month through the last day of each month.

☐ Change billing cycle to the 15th day of each month through the 14th day of the next month.

The Blue Access® for Employers ("BAE") contact person is the employee authorized by the Employer to access and maintain its account/employee information via BAE. To access and maintain BAE an email address is required.

Name and title of BAE contact person: _____

Telephone Number of BAE contact person: _____

E-Mail address of BAE contact person: _____

1. Employer has determined employees must routinely work_____ (minimum of 20) hours per week in order to be eligible for health/dental coverage under this benefit program.

2. Select a Waiting Period:
   a. Newly eligible individuals will become effective on:
      ☐ the first day of the contract/participation month following ☐ 0 days ☐ 30 days ☐ 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 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. 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: _____

3. Domestic Partners covered: ☐ Yes ☐ No

   If yes: A Domestic Partner, as defined in the Plan, 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 are not eligible for continuation coverage under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

CONTRIBUTION AND PARTICIPATION

Health Employer Contribution, the percentage * of health premium to be paid by the Employer is:

Medical -- %	
Employee Only Coverage (Single Coverage)	_____%

*The minimum contribution amount which is required from the Employer is fifty percent (50%) of the premium for Employee Only (Single Coverage).

BlueCare Dental Employer Contribution if applicable, the percentage of BlueCare Dental premium to be paid by the Employer is:

Dental -- %	
Employee Only Coverage (Single Coverage)	_____%

Minimum Participation and Employer Contribution:

Blue Cross and Blue Shield of New Mexico ("BCBSNM") reserves the right to: 1) 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 2) review participation and contribution on existing business and non-renew or discontinue health coverage 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. No dental policy will be issued or renewed unless these minimum contribution and participation requirements are met.

If applicable, BCBSNM 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 BCBSNM of any change in participation and Employer contribution.

LEGISLATIVE REQUIREMENTS

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and the **Consolidated Omnibus Budget Reconciliation Act (COBRA)** are federally mandated requirements. Employer penalties for noncompliance may apply. It is your responsibility to annually inform BCBSNM of whether **COBRA** is applicable to you based upon your full and part-time employee count in the prior calendar year.

Failure to advise BCBSNM of a change of status could subject you to governmental sanctions.

TEFRA is a Medicare secondary payer requirement that mandates employers that employ 20 or more (full-time, part-time, seasonal, or partners) total employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year to offer the same (primary) coverage to their age 65 or over employees and the age 65 or over spouses of employees of any age that they offer to younger employees and spouses.

Are you subject to TEFRA? Yes ☐ **No** ☐

COBRA

Did your company employ 20 or more full-time and/or part-time employees for at least 50% of the workdays of the preceding calendar year? **Yes** ☐ **No** ☐

Are you subject to COBRA? **Yes** ☐ **No** ☐

Do you want HCSC to administer COBRA benefits (only applies to groups subject to COBRA)? **Yes** ☐ **No** ☐

If yes is selected please complete the HCSC COBRA administration form.

MEDICARE SECONDARY PAYER RULES

Under the **Medicare Secondary Payer Rules**, it is your responsibility to annually inform BCBSNM of proper employee counts for the purpose of determining payment priority between Medicare and BCBSNM. **To satisfy this responsibility, please complete, sign, date, and respond to the *Annual Medicare Secondary Payer Employer Acknowledgement Form upon receipt*.**

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, public school districts, and "church plans" as defined by the Internal Revenue Code.

Please provide your ERISA Plan Year*: Beginning Date:_____/_____/_____ End Date:_____/_____/_____

Month Day Year Month Day Year

ERISA Plan Sponsor: _____

If you contend 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 ☐ Other; please specify: _____

Please provide Non-ERISA Plan Year:_____/_____/ _____

Month Day Year

If Non-ERISA, is your organization a church plan? ☐ **No** ☐ **Yes**

For more information regarding ERISA, contact your Legal Advisor.

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

Only complete the following Benefit Plan Selections if applicant/employer wants to make a change to their Plan and Product Options. If changes are needed, please check all applicable Product Options listed below and indicate Plan Selection(s). If intent is to retain a plan previously elected, plan number must be indicated in Plan Selections section below, otherwise plan(s) will be cancelled.

BENEFIT PLAN SELECTIONS

Understanding the Plan # Sample Plan # : **B816PPO**		
Metallic Level	B	**B**ronze, Silver, Gold, Platinum
Benefit Design	817	817, etc.
Network/Product Name	PPO	**PPO**=Blue PPO ADT= Blue Advantage HMO EPO=Blue EPO HMO=Blue HMO

Health Products/Benefit Plan Selection:

The left hand column lists the benefit designs. Up to three selections from this column are allowed. The corresponding rows to the right of the benefit designs indicate network / product choices for the specified benefit. A maximum of six network / product options may be selected. Refer to the BCBSNM rate / renewal proposal for available plan options / descriptions.

Benefit Design (select up to 3)		**Blue PPO**		**Blue Advantage HMO**		**Blue HMO**		**Blue EPO**	
		(select up to 6)							
☐	B816	☐	B816PPO						
☐	S800							☐	S800EPO

☐	S801	☐	S801PPO						
☐	S803	☐	S803PPO						
☐	S804	☐	S804PPO						
☐	S805	☐	S805PPO						
☐	S806	☐	S806PPO					☐	S806EPO
☐	S807	☐	S807PPO						
☐	S808	☐	S808PPO	☐	S808ADT	☐	S808HMO		
☐	S809							☐	S809EPO
☐	G800					☐	G800HMO		
☐	G802	☐	G802PPO						
☐	G807			☐	G807ADT				
☐	G810	☐	G810PPO						
☐	G811					☐	G811HMO		
☐	G812	☐	G812PPO	☐	G812ADT	☐	G812HMO		
☐	G813	☐	G813PPO						
☐	G814	☐	G814PPO			☐	G814HMO		
☐	G816							☐	G816EPO
☐	G817							☐	G817EPO
☐	G818							☐	G818EPO
☐	P800	☐	P800PPO						
☐	P801	☐	P801PPO						

Dental Products/Benefit Plan Selection:

Plan Pairings (Groups 10+)
True Group
Any one true group high option can be paired with any one true group low option; DNMHM12 can be freely paired with any true group.

High Option	Low Option
DNMHR01	DNMLR06
DNMHR02	DNMLR07
DNMHR03	DNMLM09

Voluntary
Any one voluntary high option can be paired with any one voluntary low option.

High Option	Low Option
DNMHR13	DNMLM15
DNMHM14	DNMHM16

Participation Requirements
True Group
>75% participation
>50% employer contribution
Voluntary
>25% participation

Employers are not required to contribute to Voluntary dental plans.

DENTAL PLAN SELECTION

	Plan #	Segment
High Coverage Allocation		
☐	DNMHR01	True Group
☐	DNMHR02	True Group
☐	DNMHR03	True Group
☐	DNMHR04	True Group
☐	DNMHM08	True Group
☐	DNMHM10	True Group
☐	DNMHM12	True Group
☐	DNMHR13	Voluntary
☐	DNMHM14	Voluntary
☐	DNMHM16	Voluntary
Low Coverage Allocation		
☐	DNMLR05	True Group
☐	DNMLR06	True Group
☐	DNMLR07	True Group
☐	DNMLM09	True Group
☐	DNMLM11	True Group
☐	DNMLM15	Voluntary

VISION PLAN SELECTION	
One Vision selection is allowed	
☐	Preferred
☐	Premier

APPLICANT STATEMENTS

1. Applicant represents and agrees that no person who is not an eligible member under this provision will be listed, named or otherwise represented by it in any way to be an eligible member, and that the applicant will not remit membership premiums for any such person or participant or assist in obtaining or maintaining a Benefit Booklet for such ineligible person. The applicant agrees to maintain complete records and to furnish to the Plan, upon request, such information as may be requested by the Plan for our underwriting review. The applicant further agrees to permit a payroll audit by the Plan or by a representative appointed by the Plan.

   Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to civil fines and criminal penalties.

2. Applicant represents and agrees the information and all attestations contained in this Benefit Program Application is true and correct and forms an essential basis for our issuance of the Contract. Even though this Benefit Program Application is submitted with the proposed premiums or other funds, there will be no coverage until this Benefit Program Application is approved by BCBSNM. Applicant agrees and understands that the amount tendered with this Benefit Program Application is based upon a proposal rate, which is subject to change. If BCBSNM approves this Benefit Program Application, BCBSNM will notify applicant and specify the effective date of group coverage. If BCBSNM does not approve this Benefit Program Application, the submitted funds will be returned to the applicant.

3. Applicant agrees to notify the Plan of ineligible persons immediately following their change in status from eligible to ineligible.

4. Applicant agrees to review all applications for completeness prior to submission to the Plan. Applicant applies for the coverages selected in this Benefit Program Application and provided in the Group Contract and agrees that the obligation of the Plan shall only include the Benefits described in the Group Contract or as amended by any Amendments or Endorsements thereto.

5. Applicant agrees to pay the required premium and to be bound by the terms and conditions of the contract. It is understood that the group health coverage is issued with no guarantee of renewability. It is understood that the benefits and rates quoted may change based on the actual enrollment of the group. Applicant agrees that an employer participation level may be required according to BCBSNM underwriting regulations and policies.

6. Applicant agrees that, in the making of this Application, it is acting for and in behalf of itself and as the agent and representative of its Eligible Persons, and it is agreed and understood that the Applicant is not the agent or representative of the Plan for any purpose of this Application or any Group Contract issued pursuant to this Application.

7. Applicant agrees to receive on behalf of its covered Eligible Persons all notices delivered by the Plan and to forward such notices to the person involved at their last known address.

8. Applicant acknowledges that if BCBSNM accepts this Benefit Program Application and issues a Group Policy, BCBSNM may pay the broker/producer a commission and/or other compensation in connection with the issuance of such Group Policy. Applicant further acknowledges that if additional information is needed regarding any commissions or other compensation paid the broker/producer by BCBSNM in connection with the issuance of the Group Policy, they should contact the broker/producer.

9. Limiting Age for covered children:
   Dependent children under age 26 are eligible for coverage until their 26th birthday. Dependent child, used hereafter, means a natural child, a stepchild, an eligible foster child, an adopted child or child placed for adoption (including a child for whom the Subscriber 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 Subscriber 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.

A Dependent child who is medically certified as disabled and dependent upon the Subscriber or his/her spouse (or Domestic Partner, if Domestic Partner coverage is elected) is eligible to continue coverage beyond the limiting age, provided the disability began before the child attained the age of 26.

Termination of coverage upon reaching the Limiting Age:

Coverage is terminated at the end of the coverage period (billing date) during which the Dependent ceases to be eligible, subject to any applicable federal or state law.

10. BCBSNM may require a minimum contribution amount from the employer of 50% of the premium for employee only (can be based on the lowest cost medical plan if multiple plans are offered).

OTHER PROVISIONS:

1. This BPA is incorporated into and made a part of the Group Contract.
2. Employer authorizes its designated broker/producer electronic access to Employer's account through the web portal identified as Blue Access for Employers (BAE) to view and perform maintenance relative to the Employer's employee benefit program on behalf of Employer, including membership eligibility, and not limited to addition and termination of members from the Employer's employee benefit program. Employer acknowledges that the accuracy of such information entered through BAE is the responsibility of the Employer.
3. Massachusetts Health Care Reform Act: Notwithstanding anything to the contrary in this BPA, with respect to the Employer's Employees who live in Massachusetts (if any) the Employer represents that it offers the health insurance benefits provided for herein to all full-time Employees, and the Employer will not make a smaller premium contribution percentage to a full-time Employee living in Massachusetts than to any other full-time Employee living in Massachusetts who receives an equal or greater total hourly or annual salary. For purposes of this representation, a "full-time Employee" is defined by Massachusetts law, generally an Employee who is scheduled or expected to work at least the equivalent of an average of thirty-five (35) hours per week.

ADDITIONAL PROVISIONS:

A. Retiree Only Plans and/or Excepted Benefits: If the BPA includes any retiree only plans and/or excepted benefits, then Employer represents 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 BCBSNM to the terms and conditions of coverage. In no event shall BCBSNM 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.

B. Religious Employer Exemption or Eligible Organization Accommodation: Federal regulations currently exempt health insurance coverage from the Affordable Care Act requirement to cover contraceptive services under guidelines supported by the Health Resources and Services Administration (HRSA) ("contraceptive coverage requirement") if the coverage is provided in connection with a group health plan established or maintained by a "religious employer" as defined in 45 C.F.R. 147.131(a) ("religious employer exemption"). In addition, health insurance coverage provided in connection with a group health plan established or maintained by an organization that qualifies for the "eligible organization accommodation" is also exempt from the contraceptive coverage requirement.

☐ No: If No, Employer does not elect to utilize the religious employer exemption or eligible organization accommodation. In the absence of an affirmative election from Employer of "No" or "Yes" in this Section, the Employer is deemed to have elected this "No" box (and no exemption or accommodation will be applied).

☐ Yes: If Yes, please choose from the following:

☐ ***Eligible Organization Accommodation.*** Employer's Self-Certification(s) for its election (and for the election of every other related organization) to utilize the eligible organization accommodation has been or will be provided to BCBSNM and is incorporated by reference. Employer acknowledges and agrees that BCBSNM will rely on such Self-Certification(s).

☐ ***Religious Employer Exemption.*** Employer represents that the following entities are religious employers and qualify for the religious employer exemption: _____

BCBSNM reserves the right to terminate acceptance of the eligible organization accommodation Self-Certification with advance written notice to the Employer.

In no event will BCBSNM be responsible for any legal, tax or other ramifications related to the Employer's elections.

C. Employer shall provide BCBSNM with immediate written notice in the event Employer and/or any of the entities listed above no longer qualify for the religious employer exemption, safe harbor, and/or eligible organization accommodation (as they may be amended, replaced or superseded from time to time). Employer shall indemnify and hold harmless BCBSNM 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 inquires or actions, settlements or judgments brought or asserted against BCBSNM in connection with (a) any plan's exempt plan status, (b) religious employer exemption safe harbor, and/or eligible organization accommodation (c) any plan's design (including but not limited to 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.

D. **ACA FEE NOTICE:** ACA established a number of taxes and fees that will affect our customers and their benefit plans. Two of those fees are: (1) the Annual Fee on Health Insurers or "Health Insurer Fee"; and (2) the Transitional Reinsurance Program Contribution Fee or "Reinsurance Fee".

Section 9010(a) of ACA requires that "covered entities" providing health insurance ("health insurers") pay an annual fee to the federal government, commonly referred to as the Health Insurer Fee. The amount of this fee for a given calendar year will be determined by the federal government and involves a formula based in part on a health insurer's net premiums written with respect to health insurance on certain health risk during the preceding calendar year. This fee will go to help fund premium tax credits and cost-sharing subsidies offered to certain individuals who purchase coverage on health insurance exchanges.

In addition, ACA Section 1341 provides for the establishment of a temporary reinsurance program(s) (for a three (3) year period (2014-2016)) which will be funded by Reinsurance Fees collected from health insurance issuers and self-funded group health plans. Federal and state governments will provide information as to how these fees are calculated. Federal regulations establish a flat, per member, per month fee. The temporary reinsurance programs funded by these Reinsurance Fees will help stabilize premiums in the individual market.

Your premium, which already accounts for current applicable federal and state taxes, includes the effects of the Health Insurer Fees and Reinsurance Fees. These rates may be adjusted on an annual basis for any incremental changes in Health Insurer Fees and Reinsurance Fees.

Notwithstanding anything in the Group Contract or Renewal(s) to the contrary, BCBSNM 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 BCBSNM to pay, submit or forward, on its own behalf or on BCBSNM's behalf, any additional tax, surcharge, fee, or other amount (all of which may be estimated, allocated or pro-rated amounts).

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.

For Employer:

Name of Authorized Company Official (please print)	Title of Authorized Company Official
Signature of Authorized Company Official	City and State of Signing Official
Date	