BlueCross BlueShield of New Mexico

P.O. Box 27630, Albuquerque, New Mexico 87125-7630

BENEFIT PROGRAM APPLICATION ("BPA")

Blue Cross and Blue Shield of New Mexico (herein called "BCBSNM")

NOTE: Your prior coverage should NOT be cancelled until you have been notified that this BPA has been accepted. No producer can bind coverage, set an effective date, or waive or alter any provisions of this BPA. Insurance is not in effect until the date established by BCBSNM.

Legal Name of Employer Group:		
If Renewing or Existing Group, Group/Account Number:		
Requested Group Contract(s) Effective Date (month/day/year): / /		
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"):

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:

ELIGIBILITY

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

2. **Select a Waiting Period:** If a person is added to the Group Contract and it is later determined that the Employer reported a coverage date earlier than what would apply to the Employee or Dependent, based on the Waiting Period and eligibility conditions the Employer provided to BCBSNM, BCBSNM reserves the right to retroactively adjust the coverage date for such person.

a. Newly eligible individuals will become effective on:

☐ the first day of the Group 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 Group Contract/participation month following satisfaction of the Waiting Period.

☐ the day the selected waiting period is satisfied: ☐ zero (0) days ☐ thirty (30) days ☐ sixty (60) days ☐ ninety (90) days.

Premiums will be billed for the entire month for Subscribers with effective dates on the first (1st) through the fifteenth (15th) of the month. Premiums will be billed beginning the next month for Participants with effective dates on the sixteenth (16th) through the end of the month.

☐ Other: _____

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 (1) month (calculated by adding one (1) calendar month and subtracting one (1) calendar day from an employee's start date); and

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

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

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

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

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

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

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

3. **Annual Open Enrollment**: For Health and Dental Plans only, an eligible individual, 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. The open enrollment period is to be held thirty (30) days prior to the Group Contract Anniversary Date of the program. Such person's Individual Coverage Date, Family Coverage Date and/or Dependent's Coverage Date will be the Group Contract Anniversary Date following the open enrollment period, provided the application is dated and signed prior to that date.

4. **Domestic Partners covered:** ☐ Yes ☐ No

If yes: A Domestic Partner, as defined in the Benefit 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 Benefit Booklet

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

☐ Other: _____

5. **Limiting Age for covered Children:** Dependent children are eligible for coverage until their twenty-sixth (26th) birthday. Dependent or 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 or Child under the Group Health Plan, provided proof of dependency is provided with the Child's application.

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

6. **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).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 age, proof of prior coverage, certification review, forms, and previous medical certification approvals.

NOTE: Employers with fifty-one (51) to one hundred fifty (150) Employees must follow standard rules

a. ☐ Disabled Dependent Administration will follow **standard rules.**

A disabled Dependent may continue coverage beyond the limiting age, provided the disability began before the child attained the age of twenty-six (26). A disabled Dependent may add coverage beyond the limiting age, provided the disability began before the child attained the age of twenty-six (26), and proof of coverage as a disabled Dependent is provided.

Certification Review is administered by BCBSNM; a Disabled Dependent Certification Form must be submitted to BCBSNM.

b. ☐ Disabled Dependent Administration will follow **custom rules**. Please make the following selections:

Age: Please select one (1) option regarding age of when the disability began.

☐ The disability must have begun before the child attained the age of twenty-six (26).

☐ All disabled Dependents are covered regardless of when the disability began.

Proof of Prior Coverage: Please select required or not required below:

When adding coverage, proof of prior coverage as a disabled Dependent is ☐ required ☐ not required.

Certification Review: Please select one (1) option regarding administration of Certification Review.

☐ Certification Review is administered by BCBSNM; a Disabled Dependent Certification Form must be submitted to BCBSNM.

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

If Certification Review is administered by BCBSNM, please select one (1) option regarding forms:

☐ BCBSNM's Disabled Dependent Certification Form will be utilized.

☐ A custom/other Disabled Dependent Certification Form will be utilized.

If Certification Review is administered by BCBSNM, please select allowed or not allowed below:

An approved disabled Dependent medical certification from a prior carrier is ☐ allowed ☐ not allowed.

An approved disabled Dependent medical certification from a prior BCBS policy is ☐ allowed ☐ not allowed.

7. Other Eligibility Provisions (please explain): _____

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 Group or Individual coverage, an Individual or SHOP Exchange policy, Medicare, Medicaid, Indian Health Services (IHS) or Military _____

BENEFIT PLAN SELECTION(S)

BluePPO Evolution℠		
☐	BluePPO Evolution $500/90%	MNEVO05002
☐	BluePPO Evolution $1000/80%	MNEVO10003
☐	BluePPO Evolution $2000/80%	MNEVO20002
☐	BluePPO Evolution $3500/80%	MNEVO35002

BlueEdge HSA℠		
☐	BlueEdge HSA $3100/80% (Vendor: Select Vendor)	MNBE831003
☐	BlueEdge HSA $3500/80% (Vendor: Select Vendor)	MNBE835002
☐	BlueEdge HSA $5000/80% (Vendor: Select Vendor)	MNBE850002
☐	BlueEdge HSA 100 $3100/100% (Vendor: Select Vendor)	MNBE131003
☐	BlueEdge HSA 100 $3500/100% (Vendor: Select Vendor)	MNBE135002
☐	BlueEdge HSA 100 $5000/100% (Vendor: Select Vendor)	MNBE150002
☐	BlueEdge HSA 100 $6900/100% (Vendor: Select Vendor)	MNBE169002

HMO Blue℠		
☐	HMO Blue $0/100%	MNHMO00002
☐	HMO Blue $500/80%	MNHMO05002
☐	HMO Blue $1000/80%	MNHMO10002
☐	HMO Blue $2000/80%	MNHMO20002

BlueNet H EPO℠		
☐	BlueNet H EPO $0/100% A	MNBNH000A2
☐	BlueNet H EPO $0/100% B	MNBNH000B2
☐	BlueNet H EPO $500/100%	MNBNH05003
☐	BlueNet H EPO $0/100% C	MNBNH000C2
☐	BlueNet H EPO $0/100% D	MNBNH000D2
☐	BlueNet H EPO $1000/100%	MNBNH10003

BlueEdge HCA℠		
☐	BlueEdge HCA $1000/70% PPO D	MNHCD10002
☐	BlueEdge HCA $1000/70% PPO S	MNHCS10002
☐	BlueEdge HCA $2500/80% PPO D	MNHCD25002
☐	BlueEdge HCA $2500/80% PPO S	MNHCS25002
☐	BlueEdge HCA $5000/70% PPO D	MNHCD50002
☐	BlueEdge HCA $5000/70% PPO S	MNHCS50002

Blue Preferred EPO℠		
☐	Blue Preferred EPO $500/80%	MNBPE05002
☐	Blue Preferred EPO $1000/80%	MNBPE10002
☐	Blue Preferred EPO $2000/80%	MNBPE20003
☐	Blue Preferred EPO $2500/70%	MNBPE25002
☐	Blue Preferred EPO $4000/70%	MNBPE40003
☐	Blue Preferred EPO $5000/70%	MNBPE50002
☐	Blue Preferred EPO $6000/70%	MNBPE60003
☐	Blue Preferred EPO $7000/70%	MNBPE70003

Blue Preferred EPO HSA 100℠		
☐	Blue Preferred EPO HSA 100 $3100/100% (Vendor: Select Vendor)	MNBP131003
☐	Blue Preferred EPO HSA 100 $5000/100% (Vendor: Select Vendor)	MNBP150002

Blue Preferred Plus℠		
☐	Blue Preferred Plus $1000/$2000 90%/60%	MNBPP10002
☐	Blue Preferred Plus $2500/$3500 90%/60%	MNBPP25002

BlueNet EPO℠		
☐	BlueNet EPO $500/80%	MNBNB05002
☐	BlueNet EPO $500/70%	MNBNC05002
☐	BlueNet EPO $750/80%	MNBNB07502
☐	BlueNet EPO $1000/80%	MNBNB10002
☐	BlueNet EPO $1000/70%	MNBNC10002
☐	BlueNet EPO $1500/70%	MNBNC15002
☐	BlueNet EPO $2000/80%	MNBNB20002
☐	BlueNet EPO $2000/70%	MNBNC20002
☐	BlueNet EPO $2500/80%	MNBNB25003
☐	BlueNet EPO $2500/70%	MNBNC25003
☐	BlueNet EPO $3000/70%	MNBNC30002
☐	BlueNet EPO $4000/80%	MNBNB40002
☐	BlueNet EPO $4000/70%	MNBNC40002
☐	BlueNet EPO $5000/80%	MNBNB50002
☐	BlueNet EPO $5000/70%	MNBNC50002
☐	BlueNet EPO $6000/80%	MNBNB60002
☐	BlueNet EPO $6000/70%	MNBNC60002
☐	BlueNet EPO $7000/80%	MNBNB70002
☐	BlueNet EPO $7000/70%	MNBNC70002

FSA purchased: ☐ Yes ☐ No (If yes, select vendor) Vendor: Select Vendor
Health Reimbursement Account (HRA) purchased: ☐ Yes ☐ No (If yes, select vendor) Vendor: Select Vendor

Vision (If Group offers medical and vision, all Members must be enrolled in both)	
☐	Preferred Vision
☐	Premier Vision

Dental	
☐	BlueCare Dental PPO℠ Contributory: Select One Voluntary: Select One
☐	Dental Plan:

Miscellaneous	
☐	Blue Directions℠ purchased (If selected, the Blue Directions Addendum is attached and made part of the Group Contract)

RATES

Product/Coverage	EE	EE+SP	EE+CH	Family
BluePPO Evolution				
HMO Blue				
BlueNet EPO				
BlueNet H EPO				
BlueEdge HSA				
BlueEdge HCA				
Blue Preferred EPO				
Blue Preferred Plus				
Insert Product/coverage				
Dental				
Vision				

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)	_____%

BCBSNM 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 Group Contract based on the enrolled participation and Employer contribution levels;

b. After the Group Contract effective date the group will be required to maintain a minimum Employer contribution of fifty percent (50%), and at least a seventy-five percent (75%) participation of eligible employees (less valid waivers) OR a minimum of fifty percent (50%) of eligible employees (including waivers). 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 unless the fifty percent (50%) minimum Employer contribution is met and at least seventy-five percent (75%) of eligible employees (less valid waivers) OR a minimum of fifty percent (50%) of eligible employees (including waivers) have enrolled for coverage.

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.

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)**, as amended, 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 twenty (20) or more total employees (full-time, part-time, seasonal, or partners) for each working day in each of twenty (20) or more calendar weeks in the current or preceding calendar year to offer the same (primary) coverage to their age sixty-five (65) or over employees and the age sixty-five (65) or over spouses of employees of any age that they offer to younger employees and spouses.

COBRA

a. Did your company employ twenty (20) or more full-time and/or part-time employees for at least fifty percent (50%) of the workdays of the preceding calendar year? ☐ Yes ☐ No

b. Are you subject to COBRA? ☐ Yes ☐ No

c. Do you want BCBSNM to administer COBRA benefits (only applies to groups subject to COBRA)? ☐ Yes ☐ No
If yes is selected, please complete the 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 at this time, please complete, sign, date, and return the Annual Medicare Secondary Payer Employer Acknowledgement Form along with this application.**

NOTE: This form is only required if you have less than one hundred fifty (150) total employees.

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.

ERISA Regulated Group Health Plan*: ☐ Yes ☐ No If Yes, specify ERISA Plan month/year*: _____/_____

ERISA Plan Sponsor*: _____

Beginning Date (month/day/year): ____/____/____ End Date: ____/____/____

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 (if selected, complete and attach the Medical Loss Ratio Assurance Form)
☐ Other; please specify: _____

Please provide your Non-ERISA Plan month/year: _____/_____

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

PRODUCER OF RECORD INFORMATION

1. Primary Producer or Agency Name (to whom commissions are to be paid) _____

Street, City, State, ZIP: _____

BCBSNM Producer #: _____ FAX number: _____

Name and phone number of Producer to contact for this case: _____

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

Medical Commission Rate _____% Dental Commission Rate _____%

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

Percentage of Split: _____

Street, City, State, ZIP: _____

BCBSNM Producer #: _____ FAX number: _____

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

If commission split, designate percentage for each Producer/Agency listed above.

1. _____% Producer/Agency

2. _____% Producer/Agency

3. Multiple Location Agency(ies): If servicing agency is not listed above as Item 1 or 2, specify location below:

_____

* 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 BCBSNM.

Sales Representative

Producer's Signature

EMPLOYER STATEMENTS

1. Employer 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 Employer will not remit membership premiums for any such person or participant or assist in obtaining or maintaining coverage for such ineligible person. The Employer agrees to maintain complete records and to furnish to BCBSNM, upon request, such information as may be requested by BCBSNM for our underwriting review. The Employer further agrees to permit a payroll audit by BCBSNM or by a representative appointed by BCBSNM.

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

3. Employer agrees to notify BCBSNM of ineligible persons immediately following their change in status from eligible to ineligible.

4. Employer agrees to review all enrollment information for completeness prior to submission to BCBSNM. Employer applies for the coverages selected in this BPA and provided in the Group Contract and agrees that the obligation of BCBSNM shall only include the Benefits described in the Group Contract or as amended by any Amendments or Endorsements thereto.

5. Employer agrees to pay the required premium and to be bound by the terms and conditions of the Group Contract. It is understood that the benefits and rates quoted may change based on the actual enrollment of the group. Employer agrees that an employer participation level may be required according to BCBSNM underwriting regulations and policies.

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

7. Employer agrees to receive on behalf of its covered Eligible Persons all notices (except for discontinuation notices, or other notices required by law to be delivered directly by BCBSNM) delivered by BCBSNM to Employer and to forward such notices to the applicable recipient(s) at their last known address.

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

9. BCBSNM may require a minimum contribution amount from the Employer of fifty percent (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 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.

4. **Summary of Benefits and Coverage ("SBC")**: The SBC Addendum is attached and made a part of the Group Contract. BCBSNM will create the SBC (only for benefits BCBSNM insures under the Group Contract) and provide the SBC to the Employer in electronic format. If the Employer approves of the content, Employer will then distribute the SBC to Members (or hire a third party to distribute) as required by law. If the Employer would like changes to the SBC, it will promptly notify BCBSNM.

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

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

7. ☐ **Wellbeing Management (WBM)**

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

ADDITIONAL PROVISIONS:

A. **Grandfathered Health Plans:** Employer shall provide BCBSNM 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 toward the cost of any tier of coverage for any class of Similarly Situated Individuals as such terms are described in the Affordable Care Act and applicable regulations. Any such changes (or failure to provide timely notice thereof) can result in retroactive and/or prospective changes by 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 benefit package of any group health insurance coverage (each hereafter a "plan") qualifying as a "grandfathered health plan" under the Affordable Care Act and applicable regulations or any representation regarding any plan's past, present and future grandfathered status. The grandfathered health plan form ("Form"), if any, shall be incorporated by reference and made part of the BPA and Group Contract, and Employer represents and agrees that such Form is true, complete, and accurate. It is understood that this information is material to the terms and conditions of coverage provided. Therefore, if Employer fails to provide BCBSNM with the above required grandfathered health plan information, information that the Employer has represented and agreed is true, accurate and complete BCBSNM reserves the ability to make retroactive and/or prospective changes to the terms and conditions of coverage, in such circumstances, to the extent allowed under applicable law. In addition, to the extent allowed under the applicable law, such changes shall also include 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 that one (1) or more such plans is not subject to some or all of the provisions of Part A (Individual and Group Market Reforms) of Title XXVII of the Public Health Service Act (and/or related provisions in the Internal Revenue Code and Employee Retirement Income Security Act) (an "exempt plan status"). If it is subsequently determined that a plan does not have exempt plan status in contradiction of Employer's representations to BCBSNM, this may materially alter the terms and conditions of coverage and may result in retroactive and/or prospective changes by BCBSNM to the terms and conditions of coverage to the extent allowed under applicable law. 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.

C. 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 inquiries or actions, settlements or judgments brought or asserted against BCBSNM in connection with (a) any plan's exempt plan status, (b) religious employer exemption, 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.

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-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.

_____

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.

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	

PROXY

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC"), or any successor thereof, with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members is scheduled to be held each year in the HCSC corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice provided to the member not less than thirty (30) nor more than sixty (60) days prior to such meetings. This proxy shall remain in effect until revoked either in writing by the undersigned at least twenty (20) days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

HCSC pays indemnification or advances expenses to its directors, officers, employees, or agents consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

Group No.: _____

By: _____
Print Signer's Name Here

➡ _____
Signature and Title

Group Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Dated this _____ day of _____ _____
Month Year