



**BlueCross BlueShield  
of New Mexico**

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

**SMALL EMPLOYER BENEFIT PROGRAM APPLICATION (“BPA”)  
(Application for Amendment)**

**Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual  
Legal Reserve Company (herein called “BCBSNM”)**

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

**ONLY COMPLETE ITEMS CHANGING on pages 1-4  
(See Page 5 for Benefit Plan change instructions)**

Legal Name of Employer Group changing to: _____		
Request to change Anniversary Date: (first (1 <sup>st</sup> ) or fifteenth (15 <sup>th</sup> )): ____/____/____ (mm/dd/yyyy)		
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: <input type="checkbox"/> Change billing cycle to the first (1 <sup>st</sup> ) day of each month through the last day of each month. <input type="checkbox"/> Change billing cycle to the fifteenth (15 <sup>th</sup> ) day of each month through the fourteenth (14 <sup>th</sup> ) day of the next month.		
The Blue Access for Employers <sup>SM</sup> (“BAE <sup>SM</sup> ”) 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: _____		

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1. Employer has determined employees must routinely work \_\_\_\_\_ (minimum of twenty (20) or other minimum number of hours permitted by law) 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 Policy and it is later determined that the Policyholder reported a coverage date earlier than what would apply to the Employee or Eligible Family Members, based on the Waiting Period and eligibility conditions the Policyholder 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 (1<sup>st</sup>) day of the Group Contract/participation month following:  
 Zero (0) days  Thirty (30) days  Sixty (60) days

Employee and Eligible Family Members Health and/or Dental Benefit Plans will become effective on the first (1<sup>st</sup>) day of the Group Contract/participation month following satisfaction of the Waiting Period and Substantive Eligibility Criteria.

b. Number of employees serving Waiting Period: \_\_\_\_\_

c. 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 (1<sup>st</sup>) 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 (1<sup>st</sup>) 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 (1<sup>st</sup>) day of the next calendar month (if start day is not the first (1<sup>st</sup>) 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 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. The open enrollment period is to be held thirty (30) days prior to the Policy Anniversary Date of the program. 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.

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.

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**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) as a spouse, but may be eligible for continuation coverage similar to that available to spouses under COBRA continuation. 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: \_\_\_\_\_

**CONTRIBUTION AND PARTICIPATION**

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

Medical -- %	
<b>Employee Only Coverage (Single Coverage)</b>	_____ %

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

BlueCare Dental<sup>SM</sup> Employer Contribution if applicable, the percentage of BlueCare Dental premium to be paid by the Employer is:

Dental -- %	
<b>Employee Only Coverage (Single Coverage)</b>	_____ %

**Minimum Participation and Employer Contribution:** 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 medical policy or contributory 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.

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## 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 (full-time, part-time, seasonal, or partners) total employees 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.

Are you subject to TEFRA?  Yes  No

### 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, please timely respond to BCBSNM's request for this information annually.**

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 \_\_\_/\_\_\_/\_\_\_ (mm/dd/yyyy)  
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 your Non-ERISA Plan Year (month/day/year): \_\_\_/\_\_\_/\_\_\_

**For more information regarding ERISA, contact your Legal Advisor.**

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

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Select ALL benefit plans that the group intends to offer, including currently offered plans.

**BENEFIT PLAN SELECTIONS**

Understanding the Plan # Sample Plan #: <b>B830PPO</b>		
Metallic Level	B	Bronze, Silver, Gold, Platinum
Benefit Design	830	830, etc.
Network/Product Name	PPO	PPO = Blue PPO <sup>SM</sup> ADT = Blue Advantage HMO <sup>SM</sup> PFR = Blue Preferred EPO <sup>SM</sup> HMO = Blue HMO <sup>SM</sup>

**Health Products/Benefit Plan Selection:**

The left-hand column lists the benefit designs. Up to three (3) 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 (6) network/product options may be selected. Refer to the BCBSNM rate/renewal proposal for available plan options/descriptions.

If HSA/HDHP is selected, provide name of HSA administrator/trustee: \_\_\_\_\_

Vendor: **Select Vendor**

FSA purchased:  Yes  No (If yes, select vendor)

Vendor: **Select Vendor**

Benefit Design (select up to 3)	Blue PPO	Blue Advantage HMO	Blue HMO	Blue Preferred EPO
	(select up to 6)			
<input type="checkbox"/> B7K1				<input type="checkbox"/> B7K1PFR
<input type="checkbox"/> B830	<input type="checkbox"/> B830PPO			
<input type="checkbox"/> B831	<input type="checkbox"/> B831PPO			
<input type="checkbox"/> B832				<input type="checkbox"/> B832PFR
<input type="checkbox"/> S7E1				<input type="checkbox"/> S7E1PFR
<input type="checkbox"/> S7E3		<input type="checkbox"/> S7E3ADT		
<input type="checkbox"/> S7E4	<input type="checkbox"/> S7E4PPO			
<input type="checkbox"/> S7E5				<input type="checkbox"/> S7E5PFR
<input type="checkbox"/> S7E7	<input type="checkbox"/> S7E7PPO			
<input type="checkbox"/> S7F1	<input type="checkbox"/> S7F1PPO			
<input type="checkbox"/> S7J1	<input type="checkbox"/> S7J1PPO			
<input type="checkbox"/> S7J2				<input type="checkbox"/> S7J2PFR
<input type="checkbox"/> S810			<input type="checkbox"/> S810HMO	
<input type="checkbox"/> S830	<input type="checkbox"/> S830PPO			
<input type="checkbox"/> S831	<input type="checkbox"/> S831PPO			
<input type="checkbox"/> S833	<input type="checkbox"/> S833PPO			
<input type="checkbox"/> S840				<input type="checkbox"/> S840PFR
<input type="checkbox"/> S842				<input type="checkbox"/> S842PFR
<input type="checkbox"/> G7E1	<input type="checkbox"/> G7E1PPO	<input type="checkbox"/> G7E1ADT	<input type="checkbox"/> G7E1HMO	<input type="checkbox"/> G7E1PFR
<input type="checkbox"/> G7E3	<input type="checkbox"/> G7E3PPO		<input type="checkbox"/> G7E3HMO	
<input type="checkbox"/> G7J3			<input type="checkbox"/> G7J3HMO	
<input type="checkbox"/> G7J5		<input type="checkbox"/> G7J5ADT		

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Benefit Design		Blue PPO		Blue Advantage HMO		Blue HMO		Blue Preferred EPO	
<input type="checkbox"/>	G801							<input type="checkbox"/>	G801PFR
<input type="checkbox"/>	G820	<input type="checkbox"/>	G820PPO						
<input type="checkbox"/>	G821	<input type="checkbox"/>	G821PPO						
<input type="checkbox"/>	G822	<input type="checkbox"/>	G822PPO						
<input type="checkbox"/>	G823	<input type="checkbox"/>	G823PPO						
<input type="checkbox"/>	G832							<input type="checkbox"/>	G832PFR
<input type="checkbox"/>	G833							<input type="checkbox"/>	G833PFR
<input type="checkbox"/>	G835							<input type="checkbox"/>	G835PFR
<input type="checkbox"/>	G836							<input type="checkbox"/>	G836PFR
<input type="checkbox"/>	P7J4			<input type="checkbox"/>	P7J4ADT				
<input type="checkbox"/>	P810	<input type="checkbox"/>	P810PPO						
<input type="checkbox"/>	P811	<input type="checkbox"/>	P811PPO						
<input type="checkbox"/>	P820							<input type="checkbox"/>	P820PFR
<input type="checkbox"/>	P821							<input type="checkbox"/>	P821PFR

Dental Products/Benefit Plan Selection:	
<p><b>Plan Pairings (Groups ten (10)+)</b></p> <p><b>Contributory</b> Any one (1) contributory high option can be paired with any one (1) contributory low option; <u>DNMHM42</u> can be freely paired with any contributory option.</p> <p><b>Voluntary</b> Any one (1) voluntary high option can be paired with any one (1) voluntary low option. <u>DNMHM46</u> can be freely paired with any one (1) voluntary option.</p> <p>Voluntary plans and contributory plans may not be offered together.</p> <p>Exception: <u>DNMHM57</u> can be paired with <u>DNMHR33</u>. And, <u>DNMHM59</u> can be paired with <u>DNMHR43</u>.</p>	<p><b>Participation Requirements</b></p> <p><b>Contributory</b> &gt;seventy-five percent (75%) participation &gt;fifty percent (50%) employer contribution</p> <p><b>Voluntary</b> &gt;twenty-five percent (25%) participation &lt;fifty percent (50%) employer contribution</p> <p>Employers are not required to contribute to Voluntary dental plans.</p>

DENTAL PLAN SELECTION		
Plan #		Segment
<b>High Coverage Allocation</b>		
<input type="checkbox"/>	DNMHR31	Contributory
<input type="checkbox"/>	DNMHR32	Contributory
<input type="checkbox"/>	DNMHR33	Contributory
<input type="checkbox"/>	DNMHR34	Contributory
<input type="checkbox"/>	DNMHM38	Contributory
<input type="checkbox"/>	DNMHM40	Contributory
<input type="checkbox"/>	DNMHM42	Contributory
<input type="checkbox"/>	DNMHR50	Contributory
<input type="checkbox"/>	DNMHM57	Contributory
<input type="checkbox"/>	DNMHR43	Voluntary

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<input type="checkbox"/>	DNMHM44	Voluntary
<input type="checkbox"/>	DNMHM46	Voluntary
<input type="checkbox"/>	DNMHR52	Voluntary
<input type="checkbox"/>	DNMHR53	Voluntary
<input type="checkbox"/>	DNMHM59	Voluntary
<b>Low Coverage Allocation</b>		
<input type="checkbox"/>	DNMLR36	Contributory
<input type="checkbox"/>	DNMLR37	Contributory
<input type="checkbox"/>	DNMLM41	Contributory
<input type="checkbox"/>	DNMLM51	Contributory
<input type="checkbox"/>	DNMLR58	Contributory
<input type="checkbox"/>	DNMLR54	Voluntary
<input type="checkbox"/>	DNMLM55	Voluntary
<input type="checkbox"/>	DNMLM56	Voluntary
<input type="checkbox"/>	DNMLR60	Voluntary

<b>VISION PLAN SELECTION</b>	
If Group offers medical and vision, all Members must be enrolled in both. One (1) vision selection is allowed.	
<input type="checkbox"/>	Preferred
<input type="checkbox"/>	Premier

## 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 under the group health plan 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.

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. Employer represents and agrees the information and all attestations contained in this Benefit Program Application are true and correct and form an essential basis for our issuance of the Group 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. Employer 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 Employer 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 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 applications for completeness prior to submission to BCBSNM. Employer applies for the coverages selected in this Benefit Program Application and provided in the Group Contract and

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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 rates quoted assume that the Employer is an eligible small Employer. If based on further information from the Employer it is determined that the Employer is a large Employer, the benefits and rates quoted may change accordingly Employer agrees that an employer participation level may be required according to the "Minimum Participation and Employer Contribution" provision above.
6. Employer 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 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 and to forward such notices to the person involved at their last known address.
8. Employer acknowledges that if BCBSNM accepts this Benefit Program Application and issues a Group Policy, BCBSNM may pay the producer a commission and/or other compensation in connection with the issuance of such Group Policy. 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 Policy, they should contact the producer.
9. **Limiting age for covered children:** Dependent children are eligible for coverage until their twenty-sixth (26th) birthday or other age permitted by law. 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 or other age permitted by law, 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.

**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.

10. **Disabled Dependent:** Disabled Dependent means a Child who is medically certified as disabled and dependent upon the Employee or his/her spouse (or Domestic Partner if Domestic Partner coverage is elected). A disabled Dependent is eligible to continue coverage beyond the limiting age, provided the disability began before the Child attained the age of twenty-six (26). A disabled Dependent is eligible to 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.

11. 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.

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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. **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.
5. **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.

#### **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 (1) or more such plans is not subject to some or all of the provisions of Part A (Individual and Group Market Reforms) of Title XXVII of the Public Health Service Act (and/or related provisions in the Internal Revenue Code and Employee Retirement Income Security Act) (an "exempt plan status"). Any determination that a plan does not have exempt plan status can result in retroactive and/or prospective changes by 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. 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-B (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.

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**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

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