BlueCross BlueShield of New Mexico

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

SMALL EMPLOYER BENEFIT PROGRAM APPLICATION ("BPA")

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

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

Legal Name of Employer Group: _____		
Requested Group Contract(s) Effective Date (first (1st) or fifteenth (15th)): _____/_____/_____ (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"): _____
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 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 (1st) 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 (1st) day of the Group Contract/participation month following satisfaction of the Waiting Period and any substantive eligibility criteria.

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

c. Number of employees serving Waiting Period: _____

d. Substantive Eligibility Criteria: Provide a representation below regarding the terms of any eligibility conditions (other than any applicable waiting period already reflected above) imposed before an individual is eligible to become covered under the terms of the plan. 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 twelve hundred (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 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 -- %	
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: 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.

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* (mm/dd/yyyy): Beginning Date ____/____/____ End Date ____/____/____
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)
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

BENEFIT PLAN SELECTIONS

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

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

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

Dental Products/Benefit Plan Selection:

Plan Pairings (Groups ten (10)+)

Contributory

Any one (1) contributory high option can be paired with any one (1) contributory low option; DNMHM42 can be freely paired with any contributory option**.**

Voluntary

Any one (1) voluntary high option can be paired with any one (1) voluntary low option. DNMHM46 can be freely paired with any one (1) voluntary option**.**

Voluntary plans and contributory plans may not be offered together.

Exception: DNMHM57 can be paired with DNMHR33. And, DNMHM59 can be paired with DNMHR43.

Participation Requirements

Contributory

>seventy-five percent (75%) participation

>fifty percent (50%) employer contribution

Voluntary

>twenty-five percent(25%) participation

<fifty percent (50%) contribution

Employers are not required to contribute to Voluntary dental plans.

DENTAL PLAN SELECTION

	Plan #	Segment
	High Coverage Allocation	
☐	DNMHR31	Contributory
☐	DNMHR32	Contributory
☐	DNMHR33	Contributory
☐	DNMHR34	Contributory
☐	DNMHM38	Contributory
☐	DNMHM40	Contributory
☐	DNMHM42	Contributory
☐	DNMHR50	Contributory
☐	DNMHM57	Contributory
☐	DNMHR43	Voluntary
☐	DNMHM44	Voluntary

☐	DNMHM46	Voluntary
☐	DNMHR52	Voluntary
☐	DNMHR53	Voluntary
☐	DNMHM59	Voluntary
Low Coverage Allocation		
☐	DNMLR36	Contributory
☐	DNMLR37	Contributory
☐	DNMLM41	Contributory
☐	DNMLM51	Contributory
☐	DNMLR58	Contributory
☐	DNMLR54	Voluntary
☐	DNMLM55	Voluntary
☐	DNMLM56	Voluntary
☐	DNMLR60	Voluntary

VISION PLAN SELECTION If Group offers medical and vision, all Members must be enrolled in both. One (1) vision selection is allowed.	
☐	Preferred
☐	Premier

PRODUCER OF RECORD INFORMATION

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

Percentage of Split: _____
(Please also complete #2 below for split commissions)

Street, City, State, ZIP: _____

9-digit Producer #: _____ FAX number:_____

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

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

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

Percentage of Split: _____

Street, City, State, ZIP: _____

9-digit Producer #: _____ FAX number:_____

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

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 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 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 (26^{th}) 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.

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 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, 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.

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, 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 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