BlueCross BlueShield of Montana
3645 Alice Street, Helena, Montana 59601
PO Box 4309, Helena, Montana 59604

BENEFIT PROGRAM MANAGED CARE APPLICATION ("Application")

Blue Cross and Blue Shield of Montana ("BCBSMT")

51 OR MORE EMPLOYEES

Account Status: Select from list

Employer Account Number (6-digits): _____ Group Number(s): _____ Section Number(s): _____

Group Contract Effective Date: _____ Group Contract Anniversary Date (AD): _____

Legal Employer Name: _____
(Specify the employer or the employee trust applying for coverage. An employee benefit plan *may not* be named.)

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

ERISA Regulated Group Health* Plan: ☐ Yes ☐ No

If Yes, is Employer's ERISA Plan Year* a period of twelve (12) months beginning on the Anniversary Date specified above? ☐Yes ☐No

If No, please specify Employer's ERISA Plan Year (month/day/year): Beginning Date __/__/____ End Date __/__/____

ERISA Plan Administrator*: _____

Plan Administrator's Address: _____

If Employer maintains that ERISA is not applicable to Employer group health plan, please give legal reason for exemption:

☐ Federal Governmental plan (e.g., the government of the United States or agency of the United States)
☐ Non-Federal Governmental plan (e.g., the government of the State, an agency of the state, or the government of a political subdivision, such as a county or agency of the State)
☐ Church plan (If selected, complete and attach the Medical Loss Ratio Assurance Form)
☐ Other; please specify: _____

Is Employer's Non-ERISA Plan Year a period of twelve (12) months beginning on the Anniversary Date specified above? ☐Yes ☐No

If No, please specify Employer's Non-ERISA Plan Year (month/day/year): Beginning Date __/__/____ End Date __/__/____

For more information regarding ERISA, contact Employer's legal advisor.

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

ACCOUNT INFORMATION

☐ **NO CHANGES** ☐ **SEE ADDITIONAL PROVISIONS**

Employer Identification Number: _____ SIC: _____ Nature of Business: _____

Primary Address: _____

City: _____ State: _____ Zip: _____

Administrative Contact: _____ Title: _____

Phone: _____ Fax: _____

Email: _____

Mailing Address (if different from Primary): _____

City: _____ State: _____ Zip: _____

Administrative Contact: _____ Title: _____

Phone: _____ Fax: _____

Email: _____

Billing Address (if different from Primary): _____

City: _____ State: _____ Zip: _____

Billing Contact: _____ Title: _____

Phone: _____ Fax: _____

Email: _____

Blue Access for Employers℠ ("BAE℠") Contact: _____ Title: _____

(The BAE Contact is an Employee who is authorized by the Employer to access and maintain the account in BAE.)

Phone: _____ Fax: _____

Email: _____

Subsidiary/Affiliated Company to be covered: _____
If necessary, list additional subsidiary companies and affiliated company addresses in the Additional Provisions section.

Contact: _____ Title: _____

Subsidiary/Affiliated Companies Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

PRODUCER OF RECORD INFORMATION

☐ **NO CHANGES**

1. *Producer/Agency** name to whom commissions are to be paid: _____

Producer Number of ☐ Producer or ☐ Agency: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

Is Producer/Agency appointed with BCBSMT? ☐ Yes ☐ No

If commissions apply, check all active lines of business, list the commission rate, and select the calculation method.

Line of Business	Commission Rate	Calculation Method
☐ Health	_____	Select from dropdown
☐ Dental	_____	Select from dropdown

2. *Producer/Agency** name to whom commissions are to be paid: _____

Producer Number of ☐ Producer or ☐ Agency: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

Is Producer/Agency appointed with BCBSMT? ☐ Yes ☐ No

If commission split, designate percentage for each Producer/Agency**. Note**: total commissions paid must equal 100%.
Producer/Agency 1: _____% Producer/Agency 2: _____%

If applicable, effective _____, the named producer(s) or agency(ies) is/are recognized as Employer's Producer of Record (POR), to act as a representative in negotiations with and to receive commissions from BCBSMT and/or corporate subsidiaries, as applicable, for procuring fully insured coverage for Employer's employee benefit program(s). This statement rescinds any and all previous POR appointments for Employer. The POR is authorized to perform membership transactions on behalf of Employer. This appointment will remain in effect until withdrawn or superseded in writing by Employer.

* 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 BCBSMT.

SCHEDULE OF ELIGIBILITY

☐ **NO CHANGES**

1. **Employee Eligibility Provisions:** All Employees working a minimum of _____ hours per week.
Specify:

- ☐ Full-time Employee of the Employer.
- ☐ Part-time Employee of the Employer.
- ☐ COBRA
- ☐ Retiree of the Employer. Define criteria: _____
- ☐ Other: _____

Are any classes of Employees to be excluded from coverage? ☐ Yes ☐ No
If Yes, please identify the classes and describe the exclusion: _____

2. **Are Spouses eligible for coverage:** ☐ Yes ☐ No

3. **Are domestic partners eligible for coverage:** (If coverage for a Spouse is not available, coverage for a domestic partner is not available.) ☐ Yes ☐ No (skip to question 4)

A Domestic Partner means a person with whom the Employee has entered into a domestic partnership in accordance with the Employer's plan guidelines. The Employer is responsible for providing notice of possible tax implications to those covered Employees with domestic partners.

Continuation coverage for domestic partners: If Employer elects coverage for Domestic Partners, Domestic Partners may be eligible for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Employer shall determine whether to continue coverage for domestic partners. Please indicate your election below:

- ☐ Yes, Employer elects to offer continuation coverage to domestic partners
- ☐ No, Employer does not elect to offer continuation coverage to domestic partners (domestic partners are not eligible for continuation coverage)
- ☐ Other: _____

4. **Probationary Waiting Period:** All current and new Employees must satisfy the substantive eligibility criteria and required waiting period in order for coverage to become effective. Covered eligible Dependents do not have to satisfy a probationary waiting period to become effective, but in no instance shall an eligible Dependent be covered prior to the Employee's effective date**.**

The effective date of coverage for a newly Eligible Employee is: (Note: No probationary waiting period may result in an effective date that exceeds ninety-one (91) calendar days from the date that an individual becomes eligible for coverage):

- ☐ The date of employment (date of hire).
- ☐ The _____ day (standard is first (1st) or fifteenth (15th)) of the month following the date of employment
- ☐ The _____ day (standard is first (1st) or fifteenth (15th)) of the month following select one days of employment.
- ☐ The _____ day (standard is first (1st) or fifteenth (15th)) of the month following select one month(s)of employment.
- ☐ The _____ day of employment (select any number of days less than or equal to ninety-one (91); examples – tenth (10th), fourteenth (14th), or twenty-first (21st) day of employment).

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 BCBSMT, BCBSMT reserves the right to retroactively adjust the coverage date for such person.

Substantive Eligibility Criteria (Optional): Provide a representation below regarding the terms of any eligibility conditions (other than any applicable waiting period already reflected above) imposed before an individual is eligible to become covered under the terms of the plan. If any of these eligibility conditions change, Employer is required to submit a new Application 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: _____

5. Are there multiple new hire probationary waiting periods? ☐ Yes ☐ No

(Note: No combined probationary waiting periods may result in an effective date that exceeds ninety-one (91) calendar days from the date that an individual becomes eligible for coverage.)

If Yes, attach eligibility and contribution details for each section.

New Groups Only - Is the probationary waiting period requirement to be waived on initial group enrollment?

Health: ☐ Yes ☐ No ☐ N/A Dental: ☐ Yes ☐ No ☐ N/A

6. The date of termination for a person who ceases to meet the definition of Eligible Employee or Dependent will be:

First (1st) of the month group renewal and billing date

☐ Last day of the month in which the covered Employee or their Dependent(s) is (are) no longer eligible.

☐ Other (please specify): _____

Fifteenth (15th) of the month group renewal and billing date

☐ Fourteenth (14th) of the month in which the covered Employee or their Dependent(s) is (are) no longer eligible

☐ Other (please specify): _____

7. The minimum standard limiting age for covered Dependent children is twenty-six (26) years. Dependent children are eligible for coverage until their twenty-sixth (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 Employee or his/her Spouse 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.

8. 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 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 BCBSMT; a Disabled Dependent Certification Form must be submitted to BCBSMT.

(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 BCBSMT; a Disabled Dependent Certification Form must be submitted to BCBSMT.
☐ Certification Review is administered by Employer/vendor; there are no Disabled Dependent Certification Form requirements.

If Certification Review is administered by BCBSMT, please select one (1) option regarding certification forms:
☐ BCBSMT's Disabled Dependent Certification Form will be utilized.
☐ A custom/other Disabled Dependent Certification Form will be utilized

If Certification Review is administered by BCBSMT, 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.

9. **Blue Directions℠ purchased:** ☐ Yes ☐ No
If Yes, the Blue Directions Addendum is attached and made part of the Group Contract.

CURRENT ELIGIBILITY INFORMATION

☐ **NO CHANGES**

Total number of Employees (Please indicate the total number of actual Employees):

1. On payroll _____
2. On COBRA continuation coverage _____
3. With retiree coverage (if applicable) _____
4. Who work part-time _____
5. Serving the new hire probationary waiting period _____
6. Declining because of other **group** coverage (e.g., other commercial group coverage, Medicare, Medicaid, TRICARE/Champus) _____
7. Declining coverage (not covered elsewhere) _____

☐ **NO CHANGES**

LINES OF BUSINESS
(Check all applicable products)

All benefits will be processed according to State and Federal mandates.

Benefit Period: ☐ Calendar Year (January 1 – December 31)
☐ Group Contract Period _____ to _____

☐ Blue Options℠	Tier I Deductible (Individual/Family)	Tier II Deductible (Individual/Family)	Tier III Deductible (Individual/Family)	Coinsurance		
				Tier I	Tier II	Tier III
Plan:	$ / $	$ / $	$ / $	%	%	%
	Copayment (PCP/Specialist)	Tier I Out-of-Pocket (Individual/Family)	Tier II Out-of-Pocket (Individual/Family)	Tier III Out-of-Pocket (Individual/Family)		
	$ / $	$ / $	$ / $	$ / $		
Plan:	Tier I Deductible (Individual/Family)	Tier II Deductible (Individual/Family)	Tier III Deductible (Individual/Family)	Coinsurance		
				Tier I	Tier II	Tier III
	$ / $	$ / $	$ / $	%	%	%
	Copayment (PCP/Specialist)	Tier I Out-of-Pocket (Individual/Family)	Tier II Out-of-Pocket (Individual/Family)	Tier III Out-of-Pocket (Individual/Family)		
	$ / $	$ / $	$ / $	$ / $		

☐ Big Sky Select	Level B Deductible (Individual/Family)	Level C Deductible (Individual/Family)	Coinsurance (In-network/Out-of-network)	Out-of-Pocket (Individual/Family)	Level A Office Visit Copay
Plan:	$ / $	$ / $	%/ %	$ / $	$
Plan:	$ / $	$ / $	%/ %	$ / $	$

☐ Blue Select®	Deductible for Prescription Drugs	Office Visit Copayment	Specialist Copayment	Emergency Room Copayment	Inpatient Admission Copayment	Out-of-Pocket (Individual/Family)
Plan:	$	$	$	$	$	$ / $
Plan:	$	$	$	$	$	$ / $

Blue Options Mid-Market Benefit Period: ☐ Calendar Year (January 1 – December 31)
☐ Group Contract Period _____ to _____

☐ Blue Options Mid-Market	Tier I Deductible (Individual/Family)	Tier II Deductible (Individual/Family)	Tier III Deductible (Individual/Family)	Coinsurance		
				Tier I	Tier II	Tier III
Marketing ID Number:	$ / $	$ / $	$ / $	%	%	%
	Copayment (PCP/Specialist)	Tier I Out-of-Pocket (Individual/Family)	Tier II Out-of-Pocket (Individual/Family)	Tier III Out-of-Pocket (Individual/Family)		
	$ / $	$ / $	$ / $	$ / $		
Marketing ID Number:	Tier I Deductible (Individual/Family)	Tier II Deductible (Individual/Family)	Tier III Deductible (Individual/Family)	Coinsurance		
				Tier I	Tier II	Tier III
	$ / $	$ / $	$ / $	%	%	%
	Copayment (PCP/Specialist)	Tier I Out-of-Pocket (Individual/Family)	Tier II Out-of-Pocket (Individual/Family)	Tier III Out-of-Pocket (Individual/Family)		
	$ / $	$ / $	$ / $	$ / $		

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)**

HCA purchased: ☐ Yes ☐ No (If yes, complete and attach a separate HCA Benefit Program Application)

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

Health Care Management Services:

☐ **Total Health Management (THM)** (additional charges apply)
☐ **Employee Assistance Program (EAP)**
☐ **Wellbeing Management (WBM)**

Dental Coverage ☐ Yes ☐ No If Yes, please list plan: _____

☐ **Vision Coverage** (if checked, attach separate application for vision coverage)

☐ **Life, Disability, Critical Illness or Accident Insurance** (if checked, attach separate application for those coverages)

☐ **BCBSMT COBRA Administrative Services** - If selected, complete separate COBRA Administrative Services Addendum. If not selected, please provide name of entity administering COBRA: _____

COMMENTS: _____

ACCOUNT EXPERIENCE – NEW GROUPS ONLY

Has there been a significant change in the claims experience previously provided?
☐ No – skip the rest of this (Account Experience) section
☐ Yes – Please answer the below questions to the best of Employer's knowledge.

Note: any changes indicated below may impact rates and will require Underwriter approval. "Member" means all Eligible Employees, Dependent children, retirees, and COBRA beneficiaries.

1. Has any Member received more than twenty thousand dollars ($20,000) in medical benefits during the last twelve (12) months? ☐ Yes ☐ No
2. Is any Member expected to have claims in excess of twenty thousand dollars ($20,000) during the next twelve (12) months? ☐ Yes ☐ No
3. Is any Member mentally or physically handicapped or disabled or not actively at work? ☐ Yes ☐ No
4. Has any Member been diagnosed as having a high-risk condition? ☐ Yes ☐ No

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

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

RATES

For the current year's premium rate information, refer to the accepted finalized new group/renewal Option Sheet for complete details. The Option Sheet shall be incorporated by reference and made part of the Application and Group Contract.

STANDARD PREMIUM INFORMATION

1. Premium Period:

☐ The first (1st) day of each calendar month through the last day of each calendar month.

☐ The fifteenth (15th) day of each calendar month through the fourteenth (14th) day of the next calendar month.

☐ 15/16 Day Rule – premiums will be billed for the entire month for Members with effective dates on the first (1st) through the fifteenth (15th) day of the month. Premiums will not be billed for the month when the Member's effective date falls on the sixteenth (16th) day through the end of the month.

2. Contribution of premium to be paid by the Employer.

PRODUCT	Employee	Eligible Dependents
HEALTH		
Plan 1	% **or** $	% **or** $
Plan 2	% **or** $	% **or** $
Plan 3	% **or** $	% **or** $
DENTAL		
Plan 1	% **or** $	% **or** $

BCBSMT 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. 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 have enrolled for coverage.

BCBSMT reserves the right to change premium rates when a substantial change occurs in the number or composition of members covered. A substantial change will be deemed to have occurred when the number of Employees/Members 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 BCBSMT of any change in participation and Employer contribution.

Additional Information/Comments: _____

BILLING SPECIFICATIONS

☐ **NO CHANGES**

The information provided within this section will be used to establish the format of Employer's billing statement(s).

Member list sorted by: ☐ Unique Identification Number (standard) ☐ Social Security Number

Please provide a detailed description of the preferred billing format (for example: Billing statement to be broken out by Department, Location, Class): _____

ID CARD DELIVERY

☐ **NO CHANGES**

Mail ID Cards to:

☐ Member's home (standard)

☐ Account

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 Employer's responsibility to annually inform BCBSMT of whether COBRA is applicable to Employer based upon Employer's full and part-time Employee count in the prior calendar year.

Failure to advise BCBSMT of a change of status could subject Employer 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.

Employer subject to TEFRA? ☐ Yes ☐ No

COBRA

COBRA allows qualified beneficiaries (generally, the covered Employee or the covered Employee's Spouse and covered Dependents) to continue to be covered by a group health plan any time the occurrence of one of more specified qualifying events would otherwise cause a loss of coverage.

a. Did Employer 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. Employer subject to COBRA? ☐ Yes ☐ No

MEDICARE SECONDARY PAYER RULES

Under the Medicare Secondary Payer Rules, it is Employer's responsibility to annually inform BCBSMT of proper Employee counts for the purpose of determining payment priority between Medicare and BCBSMT. **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.***

OTHER PROVISIONS

☐ **NO CHANGES**

1. **Summary of Benefits and Coverage ("SBC"):** The SBC Addendum is attached and made a part of the Group Contract. BCBSMT will create the SBC (only for benefits BCBSMT 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 BCBSMT. BCBSMT will also distribute the SBC to Members via regular hardcopy mail or electronically in response to occasional requests received directly from individuals. All other distribution is the responsibility of the Employer.

2. This Application is incorporated into and made a part of the Group Contract entered into and agreed upon by BCBSMT and the Employer.

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

4. **Reimbursement:** It is understood and agreed that in the event BCBSMT makes a recovery on a third-party liability claim, BCBSMT 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)**: BCBSMT engages with third-party recovery vendors and law firms on a post-pay basis to identify and/or recover any potential overpayments that may have been made to Providers.

6. **Wellness Credit**: BCBSMT will provide a one-time wellness credit of _____ for the twelve (12) month period beginning on the Group Contract Effective Date, to be used to cover costs and expenses associated with implementation and/or operation of a wellness program. If Employer cancels coverage before expiration of the Group Contract period, Employer will be required to refund BCBSMT the full amount of the wellness credit.

7. **Transition Credit**: BCBSMT will provide a one-time transition credit of _____ for the twelve (12) month period beginning on the Group Contract Effective Date, to be used to cover costs and expenses associated with transitioning medical, prescription, ancillary health or other coverage to BCBSMT and/or costs and expenses associated with transitioning to a new product design with BCBSMT. If Employer cancels before expiration of the Group Contract period, Employer will be responsible for refunding to BCBSMT the full amount of the transition credit.

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, BCBSMT 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 BCBSMT 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 towards 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 BCBSMT to the terms and conditions of coverage. In no event shall BCBSMT 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 Application and Group Contract, and Employer represents that such Form is true, complete, and accurate. If Employer fails to timely provide BCBSMT with any requested grandfathered health plan information, BCBSMT may make retroactive and/or prospective changes to the terms and conditions of coverage, including changes for compliance with state or federal laws or regulations or interpretations thereof.

B. **Retiree Only Plans and/or Excepted Benefits:** If this Application 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 BCBSMT to the terms and conditions of coverage. In no event shall BCBSMT 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. 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.

Notwithstanding anything in the Group Contract or Renewal(s) to the contrary, BCBSMT reserves the right to revise BCBSMT's charge for the cost of coverage (premium or other amounts) at any time, with sixty (60) days advance notice, 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 BCBSMT to pay, submit or forward, on its own behalf or on the Employer's behalf, any additional tax, surcharge, fee, or other amount (all of which may be estimated, allocated or pro-rated amounts).

Additional Information: _____

EMPLOYER STATEMENTS:

1. Producer Statement (if applicable): I certify that I have reviewed all enrollment materials. I have also advised the Employer that I have no authority to bind these coverages, to alter the terms of the Group Contract(s), this Application or enrollment material in any manner or to adjust any claims for benefits under the Group Contract(s).

2. BCBSMT will report to ERISA plans with one hundred (100) or more participants the value of all remuneration paid by BCBSMT for use in the ERISA plans' preparation of ERISA Form 5500 schedules. Reporting will also be provided upon request to non-ERISA plans or plans with fewer than one hundred (100) participants. Reporting will include base commissions, bonuses, incentives, or other forms of remuneration for which Employer's agent/consultant is eligible for the sale or renewal of self-funded and/or insured products.

3. The undersigned person represents that he/she is authorized and responsible for purchasing coverage on behalf of the Employer. It is understood that the actual terms and conditions of coverage are those contained in the Group Contract into which this Application shall be incorporated at the time of acceptance by BCBSMT. Upon acceptance, BCBSMT shall issue a Group Contract to the Employer and the Employer shall be referred to as the "Employer or Policyholder."

4. The Employer's Group Application must pre-date the requested effective date and be received by BCBSMT at its home office no less than thirty (30) days prior to the requested effective date.

Authorized BCBSMT Representative	Signature of Authorized Purchaser
Title	Title
Date	Date
Producer Representative (if applicable)	
BCBSMT Producer #	

Summary of Benefits and Coverage Addendum
to the Large Group Application

First date of Employer's open enrollment period for the next Plan Year (the "first open enrollment date"): _____

The Affordable Care Act ("ACA") requires group health plans and/or insurance issuers to create and distribute a Summary of Benefits and Coverage (or alternate format permitted by ACA) (the "SBC"), to Members in certain specified situations (the "SBC Requirements"). In accordance with the Employer's election on the most current Application, to have BCBSMT create and/or distribute the SBC, as of the first open enrollment date, the Employer acknowledges and agrees:

1. BCBSMT's SBC services do not include the creation or distribution of coverage information for benefits it does not insure under the Group Contract, unless otherwise agreed to in the Application or this Addendum.

2. The Employer is responsible for the proper synthesizing of information from its various insurers and administrative service providers it uses for its group health plan (or providing multiple partial SBCs if permitted by law).

3. The Employer is responsible for SBC services performed by The Employer's third-party vendors.

4. The Employer must review and approve the SBC prior to distribution and is responsible for the content of the SBC. Nothing in this Addendum or in the Group Contract relieves the Employer or its group health plan of their respective legal and regulatory obligations with respect to the SBC.

5. ACA and the SBC regulatory and sub-regulatory guidance (the "Guidance") is subject to change and the regulatory agencies and industry interpretations thereof are evolving; therefore, BCBSMT 's operations shall not be considered to be in breach of this Addendum or the Group Contract to the extent has worked diligently and in good faith to provide the SBC services, based on a reasonable interpretation of then-current SBC-related ACA provisions and Guidance, in a manner consistent with the SBC Requirements.

6. The Employer agrees to furnish to BCBSMT in a timely manner all information necessary for the timely distribution of SBCs, including but not limited to names and addresses for: (i) any person currently enrolled in any plan administered or insured by BCBSMT, and (ii) any person the Employer tells us is eligible or may become eligible. The Employer's failure to furnish such information, to agree to an implementation plan or to promptly review/approve SBCs may substantially delay and/or jeopardize BCBSMT's SBC services and BCBSMT is relieved of its SBC obligations.

7. The Employer's failure to promptly review/approve SBCs may substantially delay and/or jeopardize BCBSMT's SBC services thereby relieving BCBSMT of its SBC obligations arising under this Addendum or its associated Large Group Application.

8. BCBSMT may, but is not required to, monitor Employer's performance of its SBC obligations, audit the Employer with respect to the SBC, request and receive information, documents and assurances from the Employer with respect to the SBC, provide its own SBC (or SBC corrections) to Members, communicate with Members regarding the SBC, respond to SBC-related inquiries from Members, and/or take steps to avoid or correct potential violations of applicable laws or regulations.) The Employer will notify BCBSMT of any actual or potential non-compliance with the SBC Requirements.

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