BlueCross BlueShield of Montana

3645 Alice Street, Helena, Montana 59601
PO Box 4309, Helena, Montana 59604

RENEWING SMALL GROUP APPLICATION FOR AMENDMENT

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

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

ONLY COMPLETE ITEMS CHANGING on pages 1-3
(See Page 4 for Benefit Plan change instructions)

Legal Name of Employer Group changing to: _____		
Request to change Anniversary Date: (first (1st) or fifteenth (15th)): ____/____/____ Month Day Year		
Employer Identification Number (EIN): _____	Nature of Business: _____	Standard Industry Code: _____
Physical Address: Number, Street, City, State, Zip _____		
Mailing Address, if different from physical address: Number, Street, City, State, Zip _____		
E-Mail Address of Authorized Company Official: _____		
Billing Address (if different from mailing): Number, Street, City, State, Zip _____		Company Telephone Number: _____
Billing and Correspondence to the attention of: _____		FAX Number: _____
Billing Cycle: ☐ Change billing cycle to the first (1st) day of each month through the last day of each month. ☐ Change billing cycle to the fifteenth (15th) day of each month through the fourteenth (14th) day of the next month.		
Billing Method Selection. (If no selection is made, the Employer's benefit plan(s) will default with the current billing method): ☐ Composite Billing ☐ Age Billing		
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 of BAE contact person: _____ Title of BAE contact person: _____		
Telephone Number of BAE contact person: _____		
E-Mail address of BAE contact person: _____		
Are you adding any affiliates and/or subsidiaries? ☐ Yes ☐ No If "yes", list name(s), SIC code, and number of Employees: _____ Are you being added as an affiliate or subsidiary? ☐ Yes ☐ No If "yes", list name, SIC code, and number of Employees: _____		

The **Employee Retirement Income Security Act of 1974 (ERISA)** is a federal law that sets minimum standards for employee benefit plans in the private industry. In general, **all** employer groups, insured or ASO, are subject to ERISA provisions except for governmental entities, such as municipalities, public school districts, and "church plans" as defined by the Internal Revenue Code.

Please provide Employer's ERISA Plan (Month/Day/Year)*: Beginning Date __/__/____ End Date: __/__/____

ERISA Plan Sponsor*: _____

If Employer maintains ERISA is not applicable to the Employer's 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 city, county, school district, or other political subdivision of the state)

☐ Church plan

☐ Other, please specify: _____

Please provide Employer's Non-ERISA Plan (Month/Day/Year): __/__/____

For more information regarding ERISA, please contact Employer's Legal Advisor.
*All as defined by ERISA and/or other applicable law/regulations.

ELIGIBILITY

1. Employer has determined employees must routinely work _____ (work hours may not be less than twenty (20) or more than forty (40)) hours per week in order to be eligible for health, dental or vision coverage under this benefit program.

Employer certifies that the above hours required:

a) Are in accordance with Small Group Reform Legislation;

b) Have been made known to all employees;

c) Are not intended to exclude any individual because of risk; and

d) Apply to all employees.

2. **Probationary Waiting Period:** Newly eligible individuals will become effective on the first (1st) bill cycle day following satisfaction of the Probationary Waiting Period and any substantive eligibility criteria selected:

☐ Zero (0) days ☐ Thirty (30) days ☐ Sixty (60) days

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 (Not Common): 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, the Employer is 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:** An Employee, 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 annual open enrollment period is to be held thirty (30) days, or within another specified number of days permitted by law, prior to the Group Contract Anniversary Date of the plan. For Health and Dental Plans, such Employee's Individual Coverage Date, Family Coverage Date and/or Dependent's Coverage Date will be the Group Contract Anniversary Date following the annual open enrollment period, provided the application is dated and signed prior to that date.

4. Are Dependent Spouses and children eligible to be covered? ☐ Yes ☐ No

5. Are domestic partners eligible for coverage? (If coverage for a Spouse is not available, coverage for a domestic partner is not available.) ☐ Yes ☐ No (If no, skip to question 6).

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 is eligible for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) if the Employee elects COBRA coverage. Employer shall determine whether to continue coverage for domestic partners on an independent basis from the Employee. Please indicate your election below:

☐ Yes, Employer elects to offer continuation coverage to domestic partners on an independent basis from the Employee

☐ No, Employer does not elect to offer continuation coverage to domestic partners on an independent basis from the Employee (domestic partners are not independently eligible for continuation coverage)

☐ Other: _____

6. Retirees Covered (applicable to municipalities only): ☐ Yes ☐ No

7. **Limiting Age for covered children:** 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 Member 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.

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.

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). Disabled means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The disability must begin while the child is covered as a dependent under the Plan or as a dependent child under another employer plan and before the child attains the limiting age with no break in coverage. 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.

Administration of Certification Review is handled by BCBSMT; a Disabled Dependent Certification Form must be submitted to BCBSMT.

9. Employer subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA)? ☐ Yes ☐ No

If yes, COBRA Administrator's Name*: _____

*If selecting BCBSMT as the Employer's COBRA Administrator, please complete the COBRA Administration Service Request form.

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

BENEFIT PLAN SELECTIONS

(Select up to three (3) plans)

Plan Selection Rules

Plan Selection(s) must correlate with details provided on the BCBSMT rate proposal.

Select **UP TO three (3)** medical plans to offer. Make sure to mark the plans you want to add **AND** the plans you want to keep.

Preferred HSA Vendor: ☐ BenefitWallet ☐ Flex ☐ HSA Bank
☐ HealthEquity, Inc. (BCBSMT to send HSA enrollment to HealthEquity, Inc. ☐ Yes ☐ No)
Non-Preferred HSA Vendor: _____

Preferred FSA Vendor: ☐ BenefitWallet ☐ Flex ☐ HealthEquity, Inc. ☐ HSA Bank
Non-Preferred FSA Vendor: _____

An HSA must be paired with a qualified high deductible health plan (HDHP) and follow strict requirements set forth by the Internal Revenue Service (IRS). Employer Groups should seek advice from their independent tax advisor, legal counsel, or other professional counselor, to ensure their proposed benefit strategy with respect to HSAs, FSAs, HRAs, or other benefit arrangements does not conflict with current IRS requirements.

Metallic Levels	Blue Preferred PPO℠ (select up to 3 plans)			Blue Focus POS℠ (select up to 3 plans)		
	Keep	**Add**	**Plan Number**	**Keep**	**Add**	**Plan Number**
BRONZE PLANS				☐	☐	Blue Focus Bronze POS℠ 002 B6E1BLC
	☐	☐	Blue Preferred Bronze PPO℠ 101 B6J1PFR	☐	☐	Blue Focus Bronze POS 101 B6J1BLC
	☐	☐	Blue Preferred Bronze PPO 134 B902PFR			
SILVER PLANS				☐	☐	Blue Focus Silver POS℠ 003 S6E2BLC
				☐	☐	Blue Focus Silver POS 011 S6K3BLC
	☐	☐	Blue Preferred Silver PPO℠ 101 S6J3PFR	☐	☐	Blue Focus Silver POS 101 S6J3BLC
	☐	☐	Blue Preferred Silver PPO 117 S931PFR	☐	☐	Blue Focus Silver POS 010 S6E1BLC
	☐	☐	Blue Preferred Silver PPO 120 S932PFR	☐	☐	Blue Focus Silver POS 001 S6E3BLC
	☐	☐	Blue Preferred Silver PPO 121 S6K3PFR			
	☐	☐	Blue Preferred Silver PPO 122 S933PFR			
	☐	☐	Blue Preferred Silver PPO 127 S935PFR			
	☐	☐	Blue Preferred Silver PPO 136 S6E1PFR			
GOLD PLANS				☐	☐	Blue Focus Gold POS℠ 005 G6E1BLC
				☐	☐	Blue Focus Gold POS 007 G6E2BLC
				☐	☐	Blue Focus Gold POS 008 G6E3BLC
	☐	☐	Blue Preferred Gold PPO℠ 101 G6J2PFR	☐	☐	Blue Focus Gold POS 101 G6J2BLC

	☐	☐	Blue Preferred Gold PPO 105 G930PFR			
	☐	☐	Blue Preferred Gold PPO 107 G931PFR			
	☐	☐	Blue Preferred Gold PPO 110 G933PFR			
	☐	☐	Blue Preferred Gold PPO 111 G6K2PFR	☐	☐	Blue Focus Gold POS 009 G6K2BLC
	☐	☐	Blue Preferred Gold PPO 123 G936PFR			
	☐	☐	Blue Preferred Gold PPO 135 G6E1PFR			
PLATINUM PLANS				☐	☐	Blue Focus Platinum POS℠ 006 P6E1BLC
	☐	☐	Blue Preferred Platinum PPO℠ 101 P910PFR			
	☐	☐	Blue Preferred Platinum PPO 102 P911PFR	☐	☐	Blue Focus Platinum POS 007 P6K4BLC
	☐	☐	Blue Preferred Platinum PPO 103 P6K1PFR	☐	☐	Blue Focus Platinum POS 008 P6K1BLC

DENTAL BENEFIT PLAN SELECTION

Plan Pairings

Groups with two (2) to nine (9) enrollees may select one (1) plan. Groups with ten (10)+ enrollees may select up to two (2) plans.

Contributory

Any one (1) contributory high option can be paired with any one (1) low option; DMTHM41 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. DMTHM45 can be freely paired with any one (1) voluntary option. Voluntary plans and contributory plans may not be offered together.

Exception: DMTHM57 can be paired with DMTHR33. And, DMTHM59 can be paired with DMTHR42.

Participation Requirements

Contributory

> seventy-five percent (75%) participation

> fifty percent (50%) employer contribution

Voluntary

> twenty-five percent (25%) participation

< fifty percent (50%) employer contribution

Employers are not required to contribute to Voluntary Dental plans.

DENTAL PLAN SELECTION

☐ Yes ☐ No

Plan #			Segment
Keep	**Add**	**High Coverage Allocation**	
☐	☐	DMTHR30	Contributory
☐	☐	DMTHR31	Contributory
☐	☐	DMTHR32	Contributory
☐	☐	DMTHR33	Contributory
☐	☐	DMTHR34	Contributory
☐	☐	DMTHM39	Contributory
☐	☐	DMTHM41	Contributory
☐	☐	DMTHR50	Contributory
☐	☐	DMTHM57	Contributory
☐	☐	DMTHR42	Voluntary
☐	☐	DMTHM43	Voluntary
☐	☐	DMTHM45	Voluntary
☐	☐	DMTHR51	Voluntary
☐	☐	DMTHR52	Voluntary
☐	☐	DMTHM59	Voluntary
Keep	**Add**	**Low Coverage Allocation**	
☐	☐	DMTLR35	Contributory
☐	☐	DMTLR36	Contributory
☐	☐	DMTLR37	Contributory
☐	☐	DMTLM38	Contributory
☐	☐	DMTLM40	Contributory
☐	☐	DMTLM44	Contributory
☐	☐	DMTLR58	Contributory
☐	☐	DMTLR46	Voluntary

☐	☐	DMTLM49	Voluntary
☐	☐	DMTLR53	Voluntary
☐	☐	DMTLM54	Voluntary
☐	☐	DMTLR60	Voluntary

VISION COVERAGE (Not available without Medical Coverage): ☐ Yes ☐ No

LIFE, ACCIDENTAL DEATH & DISMEMBERMENT (AD&D), SUPPLEMENTAL LIFE AND AD&D AND SHORT-TERM DISABILITY, LONG-TERM DISABILITY, CRITICAL ILLNESS, ACCIDENT, AND STAND-ALONE VISION PLANS:

☐ Group Life, AD&D Plan Selected: _____ Employer Contribution: _____%	☐ Dependent Life Employer Contribution: _____%	☐ Supplemental Life Insurance and AD&D Employer Contribution: _____%
☐ Short-Term Disability Plan Selected: _____ Employer Contribution: _____%	☐ Long-Term Disability Plan Selected: _____ Employer Contribution: _____%	☐ Critical Illness Plan Selected: _____ Employer Contribution: _____%
☐ Accident Insurance Plan Selected: _____ Employer Contribution: _____%	☐ Stand-Alone Vision Plan Selected: _____ Employer Contribution: _____%	

With respect to the coverage applied for, Employer agrees to comply with and participate in all provisions of the Group Policy providing the coverage applied for. Employer understands BCBSMT intends to rely on this information in determining whether the enrolling employees may become insured.

EMPLOYER STATEMENTS: Applications/Declinations are attached for all full-time employees as well as any COBRA or state participant continuations.

1. **Minimum Participation Requirement:** BCBSMT reserves the right to:

a. 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 have enrolled for coverage; and

b. Request confirmation of and review participation and contribution on existing business and non-renew or discontinue health coverage if BCBSMT is unable to determine if the fifty percent (50%) minimum employer contribution is met and at least seventy-five percent (75%) of eligible employees have enrolled for coverage. No contributory dental group contract will be issued or renewed unless these minimum contribution and participation requirements are met.

2. Employer understands that unless otherwise specified in the Group Contract, only Eligible Employees and their Dependents are eligible for coverage. In some instances, the Employer may determine that only Eligible Employees are eligible for coverage. Employer further agrees that eligibility and participation requirements have been discussed with the producer and have been explained to all Eligible Employees. The Employer agrees to maintain complete records and to furnish to BCBSMT, upon request, such information as may be requested by BCBSMT for BCBSMT's underwriting review. The Employer further agrees to permit a payroll audit by BCBSMT or by a representative appointed by BCBSMT.

3. Employer agrees to notify BCBSMT of any Member or Dependent who becomes ineligible for coverage immediately following their change in status from eligible to ineligible.

4. Employer agrees to review all applications for completeness prior to submission to BCBSMT. Employer applies for the coverages selected in this Application and provided in the Group Contract and agrees that the obligation of BCBSMT shall be limited to the Benefits described in the Group Contract, except as amended by any Amendments or Endorsements thereto.

5. Employer agrees to pay to BCBSMT, in advance, the premiums specified in the Group Billing Statement on behalf of each Eligible Person covered under the Group Contract.

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

7. Employer agrees to deliver to its Members covered under the Group Contract Individual Member Guides and Identification Cards and any other relevant materials as may be furnished by BCBSMT for distribution.

8. Employer agrees to receive on behalf of its Members all notices delivered by BCBSMT and to forward such notices to the applicable recipient(s) at their last known address.

9. Employer agrees the producer(s) or agency(ies), specified in writing by the Employer as its Producer of Record (POR) is authorized by the Employer to act as its representative in negotiations with and to receive commissions from BCBSMT and HCSC subsidiaries for Employer's employee benefit programs. The POR is authorized by the Employer to perform membership transactions on behalf of the Employer and is authorized to conduct such transactions through the Employer's account through the web portal identified as BAE. The appointment will remain in effective until withdrawn or superseded in writing by Employer.

10. For the current year's premium and 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.

OTHER PROVISIONS:

1. This Application is incorporated into and made a part of the Group Contract.

2. Employer authorizes its designated POR electronic access to Employer's account through the web portal identified as 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 Employees 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 or other number of hours per week permitted by law.

   If elected below, BCBSMT will provide required written statements of Minimum Credible Coverage (MCC) to Members residing in Massachusetts and submit applicable electronic reporting to the Massachusetts Department of Revenue. Information transmitted will be exclusively based on information provided to BCBSMT by Employer and coverage under the Plan(s) during the term of this Agreement. By electing to have BCBSMT transmit these creditable coverage reports on Employer's behalf, Employer hereby certifies that, to the best of its knowledge, such coverage under the Plan(s) is "creditable coverage" in accordance with the Massachusetts Health Care Reform Act. Employer acknowledges that BCBSMT is not responsible for verifying nor ensuring compliance with any tax and/or legal requirements related to this service. Employer or its Members should seek advice from their legal or tax advisors as necessary. If not elected, Employer acknowledges it will provide written statements and electronic reporting to the Massachusetts Department of Revenue as required by the Massachusetts Health Care Reform Act.

   ☐ Employer consents to BCBSMT transmitting MCC reports on its behalf Further, Employer attests that the information submitted is true and compliant with all relevant MCC Regulations.

   ☐ Employer will transmit MCC reports and any other documentation as may be required to comply with the Massachusetts Health Care Reform Act.

4. **Reimbursement**: It is understood and agreed that in the event BCBSMT makes a recovery on a third-party liability claim, after compliance with any applicable Made Whole requirements, 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. The provisions of paragraphs 1-5 (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.

ADDITIONAL PROVISIONS:

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).

SIGNATURE

My signature below affirms that all information provided to Blue Cross and Blue Shield of Montana in applying for this Group insurance coverage is complete and accurate to the best of my knowledge. I agree to the terms and conditions of the Group Contract, and I accept the benefit plans as outlined above and rates as indicated on the attached Option Sheet.

Printed Name of Authorized Employer Representative

Signature of Authorized Employer Representative

Title

Date