BlueCross BlueShield of Montana

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

RENEWING COMMUNITY SMALL GROUP APPLICATION FOR AMENDMENT
Blue Cross and Blue Shield of Montana (herein called BCBSMT)

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

ONLY COMPLETE ITEMS THAT HAVE CHANGED FROM THE PREVIOUS BPA

Legal Name of Employer Group changing to:		
Request to change Anniversary Date: (1st or 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 day of each month through the last day of each month.

☐ Change billing cycle to the 15th day of each month through the 14th day of the next month.

Billing Method Selection:

Please select one of the following billing methods.

(If no selection is made, your benefit plan(s) will default with their current billing method)

☐ Composite Billing

☐ Age Billing

®Registered Service Marks of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans. Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

Proprietary and Confidential Information of Blue Cross and Blue Shield of Montana. Not for use or disclosure outside Blue Cross and Blue Shield of Montana, Employer, their respective affiliated companies and third party representatives, except with written permission of Blue Cross and BlueShield of Montana.

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:

1. Employer has determined employees must routinely work _____ (work hours may not be less than 20 or more than 40) hours per week in order to be eligible for health, dental or vision coverage under this benefit program. Please note, to determine eligibility for small group coverage, a work hour requirement of 30 hours will be used.

   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 day of the contract/participation month following satisfaction of the Probationary Waiting Period and any substantive eligibility criteria selected:

   ☐ 0 days ☐ 30 days ☐ 60 days

   Employees will become effective on the first billing date following completion of the Probationary 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, based on the waiting period and eligibility conditions the Policyholder provided to the Plan, the Plan 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, 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 month (calculated by adding one calendar month and subtracting one 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 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 day of the following month;
   2) Does not exceed 12 months; and
   3) Taken together with other eligibility conditions does not result in coverage becoming effective later than 13 months from the employee's start date plus the number of days between a start date and the first day of the next calendar month (if start day is not the first day of the month).

Proprietary and Confidential Information of Blue Cross and Blue Shield of Montana. Not for use or disclosure outside Blue Cross and Blue Shield of Montana, Employer, their respective affiliated companies and third party representatives, except with written permission of Blue Cross and BlueShield of Montana.

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

_____

_____

_____

3. Are dependent spouses and children eligible to be covered? ☐ Yes ☐ No
4. 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 yes: A Domestic Partner, as defined in the Plan, 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), but may be eligible for continuation coverage under the Montana conversion statute.
5. Retirees Covered (applicable to municipalities only): ☐ Yes ☐ No
6. Are you subject to Consolidated Omnibus Reconciliation Act (COBRA): ☐ Yes ☐ No

   If yes, COBRA Administrator's Name:

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

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

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 Month/Day/Year*: Beginning Date _____/_____/_____ End Date: _____/_____/_____

ERISA Plan Sponsor*: _____

If you maintain ERISA is not applicable to your 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

☐ Other, please specify:

Please provide your Non-ERISA Plan Month/Day/Year _____/_____/_____

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

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

Proprietary and Confidential Information of Blue Cross and Blue Shield of Montana. Not for use or disclosure outside Blue Cross and Blue Shield of Montana, Employer, their respective affiliated companies and third party representatives, except with written permission of Blue Cross and BlueShield of Montana.

Only complete this page if applicant/employer wants to make a change to the Plan and Product Options you were mapped to by BCBSMT. If changes are needed, please check all applicable Product Options listed below and indicate Plan Selection(s) information.

Plan Selection Rules

Plan Selection(s) must correlate with details provided on the Blue Cross and Blue Shield of Montana rate proposal.

HEALTH BENEFIT PLAN SELECTION (Select up to three plans)	
If HSA/HDHP is selected, provide name of HSA administrator/trustee: **Select Vendor**	
☐ Blue Preferred Platinum PPO 101 -- P910PFR	☐ Blue Preferred Platinum PPO 102 -- P911PFR
☐ Blue Preferred Gold PPO 105 -- G930PFR	☐ Blue Preferred Gold PPO 123 -- G936PFR
☐ Blue Preferred Gold PPO 107 -- G931PFR	☐ Blue Preferred Gold PPO 126 -- G940PFR
☐ Blue Preferred Gold PPO 110 -- G933PFR	☐ Blue Preferred Silver PPO 122 -- S933PFR
☐ Blue Preferred Gold PPO 111 -- G934PFR	☐ Blue Preferred Silver PPO 127 -- S935PFR
☐ Blue Preferred Silver PPO 117 -- S931PFR	☐ Blue Preferred Silver PPO 129 -- S936PFR
☐ Blue Preferred Silver PPO 120 -- S932PFR	☐ Blue Preferred Silver PPO 133 – B902PFR
☐ Blue Preferred Silver PPO131 -- B901PFR	☐ Blue Preferred Bronze PPO 118 -- B931PFR
☐ Blue Preferred Bronze PPO 116 -- B930PFR	☐ Blue Preferred Bronze PPO 130 – B901PFR
☐ Blue Preferred Bronze PPO 119 -- B932PFR	☐ Blue Preferred Bronze PPO 134 -- B902PFR

DENTAL PRODUCTS / BENEFIT PLAN SELECTION	
Plan Pairings (Groups 10+) **Contributory** **Any one Contributory high option can be paired with any one low option; DMTHM11 can be freely paired with any** **High Option** — **Low Option** **DMTHR01** — **DMTLR06** **DMTHR02** — **DMTLR07** **DMTHR03** — **DMTLM08** **Voluntary** **Any one voluntary high option can be paired with any one voluntary low option. DMTHM15 can be freely paired with any one voluntary option.** **High Option** — **Low Option** **DMTHR12** — **DMTLR23** **DMTHR21** — **DMTLM24**	**Participation Requirements** **Contributory** **>75% participation** **>50% employer contribution** **Voluntary** **>25% participation** **Employers are not required to contribute to Voluntary Dental plans**

DENTAL PLAN SELECTION ☐ Yes ☐ No	
Plan #	**Segment**
High Coverage Allocation	
☐ DMTHR01	Contributory
☐ DMTHR02	Contributory

Proprietary and Confidential Information of Blue Cross and Blue Shield of Montana. Not for use or disclosure outside Blue Cross and Blue Shield of Montana, Employer, their respective affiliated companies and third party representatives, except with written permission of Blue Cross and BlueShield of Montana.

☐ DMTHR03	Contributory
☐ DMTHR04	Contributory
☐ DMTHM09	Contributory
☐ DMTHM11	Contributory
☐ DMTHR20	Contributory
☐ DMTHR12	Voluntary
☐ DMTHM13	Voluntary
☐ DMTHM15	Voluntary
☐ DMTHR21	Voluntary
☐ DMTHR22	Voluntary
Low Coverage Allocation	
☐ DMTLR05	Contributory
☐ DMTLR06	Contributory
☐ DMTLR07	Contributory
☐ DMTLM08	Contributory
☐ DMTLM10	Contributory
☐ DMTLR23	Voluntary
☐ DMTLM24	Voluntary

VISION COVERAGE (Not available without Medical Coverage)

☐ Yes ☐ No

APPLICANT 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: 1) restrict new business enrollment in health insurance coverage to open or special enrollment periods unless the 50% minimum employer contribution is met and at least 75% of eligible employees have enrolled for coverage; and 2) review participation and contribution on existing business and non-renew or discontinue health coverage unless the 50% minimum employer contribution is met and at least 75% of eligible employees have enrolled for coverage. No dental policy will be issued or renewed unless these minimum contribution and participation requirements are met.
2. Applicant 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 Employees are eligible for coverage. Applicant further agrees that eligibility and participation requirements have been discussed with the producer and have been explained to all Eligible Members. The applicant agrees to maintain complete records and to furnish to BCBSMT, upon request, such information as may be requested by BCBSMT for our underwriting review. The applicant further agrees to permit a payroll audit by BCBSMT or by a representative appointed by the Plan.
3. Applicant agrees to notify BCBSMT of ineligible persons immediately following their change in status from eligible to ineligible.

Proprietary and Confidential Information of Blue Cross and Blue Shield of Montana. Not for use or disclosure outside Blue Cross and Blue Shield of Montana, Employer, their respective affiliated companies and third party representatives, except with written permission of Blue Cross and BlueShield of Montana.

4. Applicant agrees to review all applications for completeness prior to submission to BCBSMT. Applicant applies for the coverages selected in this Application and provided in the Contract and agrees that the obligation of the Plan shall only include the Benefits described in the Contract or as amended by any Amendments or Endorsements thereto.

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

6. Applicant 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 Members, and it is agreed and understood that the Applicant is not the agent or representative of the Plan for any purpose of this Application or any Contract issued pursuant to this Application.

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

8. Applicant agrees to receive on behalf of its covered Members all notices delivered by BCBSMT and to forward such notices to the person involved at their last known address

9. Applicant 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 Blue Cross and Blue Shield of Montana, a division of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company, 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 web portal known as Blue Access for Employers (BAE). The appointment will remain in effective until withdrawn or superseded in writing by Employer.

10. **Limiting Age for covered children:** Dependent children under age 26 are eligible for coverage until their 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.

    A Dependent child who is medically certified as disabled and dependent upon the Member or his/her spouse is eligible to continue coverage beyond the limiting age, provided the disability began before the child attained the age of 26.

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

11. 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 broker/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. **Religious Employer Exemption and Eligible Organization Accommodation**: Although federal regulations describe a limited exemption for certain group health plans from the Affordable Care Act requirement to cover contraceptive services under guidelines supported by the Health Resources and Services Administration (HRSA), your insurance Group Contract must comply with applicable state requirements regarding contraceptive coverage. Accordingly, your Group Contract currently includes coverage for contraceptives consistent with the state and federal coverage requirements and applicable exemptions. Some contraceptives may be covered without cost to the Member.

4. The provisions of paragraphs 1-3 (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.

Proprietary and Confidential Information of Blue Cross and Blue Shield of Montana. Not for use or disclosure outside Blue Cross and Blue Shield of Montana, Employer, their respective affiliated companies and third party representatives, except with written permission of Blue Cross and BlueShield of Montana.

ADDITIONAL PROVISIONS:

ACA FEE NOTICE: ACA established a number of taxes and fees that will affect our customers and their benefit plans. One of those fees is: the Annual Fee on Health Insurers or "Health Insurer Fee."

Section 9010(a) of ACA requires that "covered entities" providing health insurance ("health insurers") pay an annual fee to the federal government, commonly referred to as the Health Insurer Fee. The amount of this fee for a given calendar year will be determined by the federal government and currently involves a formula based in part on a health insurer's net premiums written with respect to health insurance on certain health risk during the preceding calendar year. This fee will go to help fund premium tax credits and cost-sharing subsidies offered to certain individuals who purchase coverage on health insurance exchanges.

In addition, ACA Section 1341 and/or other applicable laws may provide for the establishment of a temporary reinsurance program(s) that may be funded by reinsurance contributions or other amounts (collectively, the "Reinsurance Fees or Amounts") collected from health insurance issuers and/or self-funded group health plans. Federal and/or state governments may provide information as to how these Reinsurance Fees or Amounts are calculated. Federal regulations establish a flat, per member, per month fee. The temporary reinsurance programs funded by these Reinsurance Fees or Amounts will help stabilize premiums in the individual market.

Your premium, which already accounts for current applicable federal and state taxes, includes the effects of the Health Insurer Fees and Reinsurance Fees or Amounts, if any. To the extent allowed by law, these rates may be adjusted on an annual basis for any incremental changes in Health Insurer Fees and Reinsurance Fees or Amounts, if any.

Notwithstanding anything in the Policy or Renewal(s) to the contrary, BCBSMT reserves the right to revise our 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 Policyholder's behalf, any additional tax, surcharge, fee, or other amount (all of which may be estimated, allocated or pro-rated amounts).

Proprietary and Confidential Information of Blue Cross and Blue Shield of Montana. Not for use or disclosure outside Blue Cross and Blue Shield of Montana, Employer, their respective affiliated companies and third party representatives, except with written permission of Blue Cross and BlueShield of Montana.

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

Proprietary and Confidential Information of Blue Cross and Blue Shield of Montana. Not for use or disclosure outside Blue Cross and Blue Shield of Montana, Employer, their respective affiliated companies and third party representatives, except with written permission of Blue Cross and BlueShield of Montana.