

Benefit Program Application ("ASO BPA")

Application to Administrative Services Only (ASO) Group Accounts

administered by Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, hereinafter referred to as the "Claim Administrator" or "HCSC"

Group Status: Off-Cycle Change

Employer Account Number (6-digits): 021185 Group Number(s): 021185 Section Number(s): ALL

Legal Employer Name: Hidalgo County

(Specify the Employer or the employee trust applying for coverage. Names of subsidiary or affiliated companies to be covered must also be named below. AN EMPLOYEE BENEFIT PLAN MAY NOT BE NAMED)

ERISA Regulated Group Health Plan*: Yes No

If Yes, is your ERISA Plan Year* a period of 12 months beginning on the Anniversary Date specified below? Yes No

If No, please specify your ERISA Plan Year*: Beginning Date ___/___/___ End Date ___/___/___ (month/day/year)

ERISA Plan Administrator*: _____ Plan Administrator's Address: _____

If you maintain that ERISA is not applicable to your group health plan, give legal reason for exemption:

Select legal reason ; if applicable, specify other: _____

Is your Non-ERISA Plan Year* a period of 12 months beginning on the Anniversary Date specified below? Yes No

If No, please specify your Non-ERISA Plan Year*: Beginning Date ___/___/___ End Date ___/___/___ (month/day/year)

For more information regarding ERISA, contact your Legal Advisor.

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

Effective Date of Coverage: (Month/day/Year) 07 / 01 / 2016

Anniversary Date: (Month/Day/Year) 01 / 01 / 2017

Account Information

NO CHANGES

SEE ADDITIONAL PROVISIONS

Standard Industry Code (SIC): _____

Employer Identification Number (EIN): _____

Address: _____

City: _____

State: _____

ZIP: _____

Administrative Contact: _____

Title: _____

Email Address: _____

Phone Number: _____

Fax Number: _____

Mailing address is different from primary address

Mailing Address: _____

City: _____

State: _____

ZIP: _____

Mailing Contact: _____

Title: _____

Email Address: _____

Phone Number: _____

Fax Number: _____

Billing address is different from primary address

Billing Address: _____

City: _____

State: _____

ZIP: _____

Billing Contact: _____

Title: _____

Email Address: _____

Phone Number: _____

Fax Number: _____

Wholly Owned Subsidiaries: _____

Affiliated Companies: _____

(If Affiliated Companies listed above are to be covered, a separate "Addendum to the Benefit Program Application Regarding Affiliated Companies" must be completed, signed by the Employer's authorized representative, and attached to this Benefit Program Application.)

If necessary, list additional subsidiary companies and subsidiary company addresses in the Additional Provisions section.

Subsidiary / Affiliate Address: _____

City: _____

State: _____

ZIP: _____

Subsidiary / Affiliate Contact: _____ Title: _____
 Email Address: _____ Phone Number: _____ Fax Number: _____
 Blue Access for Employers (BAE) Contact: _____ Title: _____
 (The BAE Contact is the Employee authorized by the Employer to access and maintain the Employer's account in BAE.)
 Email Address: _____ Phone Number: _____ Fax Number: _____
 The Employer or other company listed in this BPA is a public Entity or governmental agency/contractor

Producer of Record	NO CHANGES	SEE ADDITIONAL PROVISIONS
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Effective: _____
 If applicable, the below-named producer(s) or agency(ies) is/are recognized as the Employer's Producer of Record (POR) to act as representative in negotiations with and to receive commissions from Blue Cross and Blue Shield of Texas, a division of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company, and HCSC subsidiaries for Employer's employee benefit programs. This statement rescinds any and all previous POR appointments for the Employer. The POR is authorized to perform membership transactions on behalf of the Employer. This appointment will remain in effect until withdrawn or superseded in writing by Employer.

Producer or Agency to whom commissions are to be paid*: _____
 Tax ID Number (TIN) of Producer or Agency: _____ Producer #: _____
 NPN: _____
 Address: _____
 City: _____ State: _____ ZIP: _____
 Phone: _____ Fax: _____ Email: _____
 Is Producer/Agency appointed with HCSC in Texas? Yes No
 General Agent? Yes No
 Affiliated with General Agent? Yes No

Is there a secondary Producer or Agency to whom commissions are to be paid? Yes No
If Yes, Producer or Agency to whom commissions are to be paid*:** _____
 Tax ID Number (TIN) of Producer or Agency: _____ Producer #: _____
 NPN: _____
 Address: _____
 City: _____ State: _____ ZIP: _____
 Phone: _____ Fax: _____ Email: _____
 Is Producer /Agency appointed with HCSC in Texas? Yes No
 General Agent? Yes No
 Affiliated with General Agent? Yes No

If commission split**, designate percentage for each producer/agency (total commissions paid must equal 100%):
 Producer /Agency 1: _____% Producer /Agency 2: _____%

Multiple Location Agency(ies): If servicing agency is not listed above as primary or secondary Producer or Agency above, 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 HCSC in Texas.

SCHEDULE OF ELIGIBILITY

NO CHANGES **SEE ADDITIONAL PROVISIONS**

Employer has made the following eligibility decisions

1. Eligible Person means:

- A full-time employee of the Employer.
- A full-time employee of the Employer who is a member of: _____ (*name of union*)
- A part-time employee of the Employer.
- A 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. Employee Definitions:

Full-Time Employee means:

- A person who is regularly scheduled to work a minimum of _____ hours per week and who is on the permanent payroll of the Employer.
- Other: _____

Part-Time Employee means:

- A person who is regularly scheduled to work a minimum of _____ hours per week and who is on the permanent payroll of the Employer.
- Other: _____

3. The Effective Date of termination for a person who ceases to meet the definition of Eligible Person:

- The date such person ceases to meet the definition of Eligible Person.
- The last day of the calendar month in which such person ceases to meet the definition of an Eligible Person
- Other: _____

4. Select an effective date rule for a person who becomes an Eligible Person after the Effective Date of the Employer's health care plan (The effective date must not be later than the 91st calendar day after the date that a newly eligible person becomes eligible for coverage, unless otherwise permitted by applicable law).

- The date of employment.
- The _____ day of employment.
- The _____ day of the month following _____ month(s) of employment.
- The _____ day of the month following _____ days of employment.
- The _____ day of the month following the date of employment.
- Other: _____

Is the waiting period requirement to be waived on initial group enrollment? Yes No

Are there multiple new hire waiting periods? Yes No

If yes, please attach eligibility and contribution details for each section.

5. Domestic Partners covered? Yes No

If yes: a Domestic Partner is eligible to enroll for coverage.

If yes, are Domestic Partners eligible for continuation of coverage? Yes No

If yes, are dependents of Domestic Partners eligible for coverage? Yes No

If yes, are dependents of Domestic Partners eligible for continuation of coverage? Yes No

The Employer is responsible for providing notice of possible tax implications to those Covered Employees with coverage for Domestic Partners.

6. Limiting Age for covered children

- i. Twenty-six (26) years, 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. (Standard)
- ii. The Limiting Age for covered children age of twenty-six (26) or over,
 - who are unmarried
 - regardless of marital status,is ____ years. (Twenty-seven (27) through thirty (30) are the available options.)
- iii. The Limiting Age for covered children who are full-time students and age twenty-six (26) or over,
 - who are unmarried
 - regardless of marital status,is ____ years. (Twenty-seven (27) through thirty (30) are the available options.)

Student status certification: Employer or HCSC or None

Frequency of Certification Letters: Annually (AN) Quarterly (QU) Semi-Annually (SA)

* Certification Schedule: Month 1 Month 2 Month 3 Month 4

* For Annual certification letters,, indicate one month (Jan-Dec), for Semi-annual, select 2 months, for quarterly, select 4 months

7. Are unmarried step-children under the limiting age eligible for coverage? Yes No
If yes, is residency with the employee required? Yes No

8. Are unmarried grandchildren eligible for coverage?

No Yes (answer the question below)

Must the grandchild be dependent on the employee for federal income tax purposes at the time application is made? Yes No

9. Termination of coverage upon reaching the Limiting Age:

- The last day of coverage is the day prior to the birthday.
- The last day of coverage is the last day of the month in which the limiting age is reached.
- The last day of coverage is the last day of the billing month.
- The last day of coverage is the last day of the year (12/31) in which the limiting age is reached.
- The last day of coverage is the day prior to the Employer's Anniversary Date.

Automatically cancel dependents when they reach the day their coverage terminates

Yes No

Will coverage for a child who is medically certified as disabled and dependent on the employee terminate upon reaching the limiting age even if the child continues to be both disabled and dependent on the employee?

Yes No

However, such coverage shall be extended in accordance with any applicable federal or state law. *The Employer will notify HCSC of such requirements.*

10. Will extension of benefits due to temporary layoff, disability or leave of absence apply?

Yes (specify number of days below) No

Temporary Layoff: _____ days Disability: _____ days

Leave of Absence: _____ days

However, benefits shall be extended for the duration of an Eligible Person's leave in accordance with an applicable federal or state law. The Employer will notify HCSC of such requirements.

11. Enrollment:

Special Enrollment: An Eligible Person may apply for coverage, Family coverage or add dependents within thirty-one (31) days of a Special Enrollment qualifying event if he/she did not previously apply prior to his/her Eligibility Date or when otherwise eligible to do so. Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be the effective date of the qualifying event or, in the event of Special Enrollment due to marriage or termination of previous coverage, then no later than the first day of the Plan Month following the date of receipt of the person's application of coverage.

An Eligible Person may apply for coverage within sixty (60) days of a Special Enrollment qualifying event in the case either of a loss of coverage under Medicaid or a state Children's Health Insurance program, or eligibility for group coverage where the Eligible Person is deemed qualified for assistance under a state Medicaid or CHIP premium assistance program.

Late Enrollment: An Eligible Person may apply for coverage, family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so. Such person's Coverage Date, family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by the Claim Administrator and the Employer.

Annual open enrollment – late applicant may apply during open enrollment and be subject to the late applicant provisions.

Late applicants may apply at any time – coverage is effective first of the month following receipt of the application.

Open Enrollment: An Eligible Person may apply for coverage, family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so, during the Employer's Open Enrollment Period. Such person's Coverage Date, family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by the Claim Administrator and the Employer. Such date shall be subsequent to the Open Enrollment Period.

Specify Open Enrollment Period: _____

12. * Does COBRA Auto Cancel apply? Yes No

Member's COBRA/Continuation of Coverage will be automatically cancelled at the end of the member's eligibility period.

**Not recommended for accounts with automated eligibility*

CURRENT ELIGIBILITY INFORMATION

NO CHANGES **Current number of Employees enrolled** _____ **SEE ADDITIONAL PROVISIONS**

Current Employee Eligibility Information only applies to new accounts. If your account is renewing, please just indicate the current number of enrolled employees (above).

Total number of Employees/Subscribers:

1. on payroll _____
2. total number of employees presently eligible for coverage _____
3. on COBRA continuation coverage _____
4. with retiree coverage (if applicable) _____
5. who work part-time _____
6. serving the new hire waiting period _____
7. declining because of other **group** coverage (e.g., other commercial group coverage, Medicare, Medicaid, TRICARE/Champus) _____
8. declining coverage (not covered elsewhere) _____

Managed Health Care Coverage:

- PPO: Plan Name: _____
 Plan Name: _____
 Plan Name: _____
 Plan Name: _____
 Plan Name: _____
- HMO: Plan Name: _____
 Prescription Drug Option: Select From List
 No Prescription Drug Option
- EPO: Plan Name: _____
- POS: Plan Name: _____
- Blue Directions (Private Exchange) *(If selected, the Blue Directions Addendum must be attached and made a part of the Agreement.)*

Consumer Driven Health Plan (BlueEdge)

- HCA, *(if selected, complete separate HCA Benefit Program Application)*
- HSA, *(if selected, provide HSA Administrator or trustee name: _____)*
- FSA (vendor: ConnectYourCare)

Traditional coverage:

- Out-of-Area (Indemnity)
- Benefit Offering

Prescription Drug Coverage:

- Prescription Drug Program
- Stand-Alone Prescription Drug Program

Dental Coverage

- Plan Name: _____ Select From List
- Plan Name: _____ Select From List
- Plan Name: _____ Select From List
- Plan Name: _____ Select From List
- Plan Name: _____ Select From List

Vision Coverage

In-Hospital Indemnity (IHI)

Wellness Incentives

Stop Loss Coverage *(If selected, complete separate Stop Loss exhibit)*

Dearborn National Life Insurance *(If selected, complete separate Life application)*

HCSC COBRA Administrative Services *-(If selected, complete separate COBRA Administrative Services Addendum to the BPA)*

Additional Comments: Effective 07-01-2016 Failure to call the BVA within 60 days when seeking services for a CT Scan or MRI will result in a \$250 penalty.

FEE SCHEDULE

Payment Specifications **NO CHANGES** **SEE ADDITIONAL PROVISIONS**

Employer Payment Method: Online Bill Pay Electronic Auto Debit Check

Employer Payment Period: **Weekly** (cannot be selected if Check is selected as payment method above)
 Semi Monthly
 Monthly
 Other (please specify): _____

Claim Settlement Period: **Monthly** **Other** (please specify): _____

Run-Off Period: Employer Payments are to be made for _____ months following the end of the Fee Schedule Period.
Standard is twelve (12) months.

Final Settlement: Final Settlement to be made within _____ days after end of Run-Off Period.
Standard is ninety (90) days.

Fee Schedule Period **NO CHANGES** **SEE ADDITIONAL COMMENTS**

To begin on Effective Date of Coverage and continue for:
 12 Months **Other** (please specify): _____ Months

Administrative Charge(s)

NO CHANGES **SEE ADDITIONAL COMMENTS**

- Applies to all coverages
- Different percentage(s) or amount(s) for the following types of coverages. Please specify:

Administrative Charge Chart:
 Each column can be used to differentiate fees between product types or employee tiers. All columns do not need to be used. All fees listed are per employee per month.

Administrative Per Employee per Month (PEPM) Charges

Product / Service				
Medical Administrative Fee	\$ _____	\$ _____	\$ _____	\$ _____
Commissions	\$ _____	\$ _____	\$ _____	\$ _____
Dental	\$ _____	\$ _____	\$ _____	\$ _____
Claims Fiduciary	\$ _____	\$ _____	\$ _____	\$ _____
Prescription Drug Administrative Fee	\$ _____	\$ _____	\$ _____	\$ _____
*Prescription Drug Rebate Credit	\$ _____	\$ _____	\$ _____	\$ _____
Outpatient Imaging Management Services	\$ _____	\$ _____	\$ _____	\$ _____
Other: Select Service Category List Service: _____	\$ _____	\$ _____	\$ _____	\$ _____
Other: Select Service Category List Service: _____	\$ _____	\$ _____	\$ _____	\$ _____

Other: Select Service Category List Service: _____	\$ _____	\$ _____	\$ _____	\$ _____
Miscellaneous: _____	\$ _____	\$ _____	\$ _____	\$ _____
Miscellaneous: _____	\$ _____	\$ _____	\$ _____	\$ _____
Total	\$ _____	\$ _____	\$ _____	\$ _____

*Prescription Drug Rebate Credit per Covered Employee per month is the guaranteed Prescription Drug Rebate savings reflected as a Prescription Drug Rebate credit. Expected rebate amounts to be received by the Claim Administrator are passed back to the Employer with one hundred percent (100%) of the expected amount applied as a credit on the monthly billing statement on a per Covered Employee per month basis. Rebate credits are paid prospectively to the Employer and shall not continue after termination of the Prescription Drug Program. (Further information concerning this credit is included in the governing Administrative Services Agreement (“Agreement”) to which this ASO BPA is attached under the section titled “CLAIM ADMINISTRATOR’S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS.”) Rebates for some drugs covered under the medical benefit are retained by the Claim Administrator as compensation for its administrative services.

Administrative Line Item Charges	Frequency	Amount
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	\$ _____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	\$ _____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	\$ _____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	\$ _____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	\$ _____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	\$ _____
Total:		\$ _____

Note: Additional services and/or fees may be itemized in the “Miscellaneous” fields above or in the Additional Comments section below.

Additional Comments (Provide any additional details regarding the fee structure): _____

Claim Administrator Provider Access Fee(s)	NO CHANGES	SEE ADDITIONAL PROVISIONS
Group Number(s):		
<input type="checkbox"/> % of ADP Savings: %		
<input type="checkbox"/> \$ per Covered Employee per month: \$		
BlueCard Program/Network access fee: Available upon request.		

Other Service and/or Program Fee(s)	NO CHANGES	SEE ADDITIONAL PROVISIONS
Not applicable to Grandfathered Plans		
External Review Coordination: <input type="checkbox"/> Yes (Claim Administrator coordinates external reviews) <input type="checkbox"/> No		
If selected, Employer acknowledges and agrees: (i) to a fee of \$700 for each external review requested by a Covered Person that the Claim Administrator coordinates for the Employer in relation to the Employer’s Plan; (ii) that the Claim Administrator’s coordination shall include reviewing external review requests to ensure that they meet eligibility requirements, referring requests to accredited external independent review organizations, and reversing the Plan’s determinations if so indicated by external independent review organizations; and (iii) that the external reviews shall be		

performed by an independent third party entity or organization and not the Claim Administrator. Amounts received by Claim Administrator and external independent review organizations may be revised from time to time and may be paid each time an external review is undertaken. Further, Employer elects for external reviews to be performed under the process selected below (select one):

- State of Texas External Review Process
- Federal Affordable Care Act Process

Reimbursement Service: Yes No

If yes: The Employer has elected to utilize the reimbursement service offered by the Claim Administrator, the Corporate Reimbursement Subrogation department. It is understood and agreed that in the event the Claim Administrator makes a recovery on a third-party liability claim, the Claim Administrator will retain 25% of any recovered amounts other than recovered amounts received as a result of or associated with any Workers' Compensation Law.

Claim Administrator's Third Party Recovery Vendor:

Recoveries from healthcare providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital audits, credit balance audits, data mining, utilization review refunds, and unsolicited refunds. The Claim Administrator may engage a third party to assist in identification or collection of recovery amounts related to Claim Payments. It is understood and agreed that in the event the Claim Administrator's Third Party Recovery Vendor makes a recovery on a claim, the Employer will pay no more than 25% of any recovered amount.

Alternative Compensation Arrangements:

Employer acknowledges and agrees that Claim Administrator has Alternative Compensation Arrangements with contracted providers, including but not limited to Accountable Care Organizations and other Value Based Programs. Further information concerning Employer's payment for covered services under such Arrangements is described in the Administrative Services Agreement.

Termination Administrative Charges

As applies to the Run-Off Period indicated in the Payment Specifications section below:

- i. **For service charges (including, but not limited to, access fees) billed on a per Covered Employee basis at the time of termination**, the Termination Administrative Charge will be the amount equal to ten percent (10%) of the annualized charges based on the service charges in effect as of the termination date and the Plan participation of the two (2) months immediately preceding the termination date. Such aggregate amount will be due the Claim Administrator within ten (10) days of the Claim Administrator's notification to the Employer of the Termination Administrative Charge described herein.
- ii. **For service charges (including, but not limited to, access fees) billed on a basis other than per Covered Employee at the time of termination**, the Termination Administrative Charge will be such service charges in effect at the time of termination to be applied and billed by the Claim Administrator, and paid by the Employer, in the same manner as prior to termination.

Termination Administrative Charges assume the continuation of the Plan benefit Program(s) and the administrative services in effect prior to termination. Should such Plan benefit program(s) and/or administrative services change, or in the event the average Plan enrollment during the three (3) months immediately preceding termination varies by ten percent (10%) or more from the enrollment used to determine the service charges in effect at the time of termination, the Claim Administrator reserves the right to adjust the fees for service charges (including, but not limited to, access fees) to be used to compute the Termination Administrative Charge.

The Termination Administrative Charge applicable to the Run-Off Period shall be equal to the sum of the amounts obtained by multiplying the total number of Covered Employees by category (*per Covered Employee per individual or family composite*) during the three (3) months immediately preceding the date of termination by the appropriate factors shown below.

Product /Service				
Medical Run-off Administration Charge	\$ _____	\$ _____	\$ _____	\$ _____
Dental Run-off Administration Charge	\$ _____	\$ _____	\$ _____	\$ _____
Miscellaneous	\$ _____	\$ _____	\$ _____	\$ _____
Miscellaneous	\$ _____	\$ _____	\$ _____	\$ _____
Total:	\$ _____	\$ _____	\$ _____	\$ _____

Additional Comments: _____

OTHER PROVISIONS

NO CHANGES **SEE ADDITIONAL PROVISIONS**

1. Summary of Benefits & Coverage:

a. Will Claim Administrator create Summary of Benefits & Coverage (SBC)?

- Yes. (Please answer question b. The SBC Addendum is attached.)
- No. If No, then the Employer acknowledges and agrees that the Employer is responsible for the creation and distribution of the SBC as required by Section 2715 of the Public Health Service Act (42 USC 300gg-15) and SBC regulations (45 CFR 147.200), as supplemented and amended from time to time, and that in no event will the Claim Administrator have any responsibility or obligation with respect to the SBC. The Claim Administrator is not obligated to respond to or forward misrouted calls, but may, at its option, provide participants and beneficiaries with Employer's contact information. (Skip question b.)

b. Will Claim Administrator distribute the Summary of Benefits & Coverage (SBC) to participants and beneficiaries?

- No. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and provide SBC to Employer in electronic format. Employer will then distribute SBC to participants and beneficiaries (or hire a third party to distribute) as required by law.
- Yes. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and provide SBC to Employer in electronic format. Employer will then distribute to participants and beneficiaries as required by law, except that Claim Administrator will send the SBC in response to the occasional request received directly from individuals.
- Yes. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and distribute SBC to participants and beneficiaries via regular hardcopy mail or electronically. Distribution Fee for hardcopy mail is \$1.50 per package. The distribution fee will not apply to SBCs that Claim Administrator sends in response to the occasional request received directly from individuals.

2. Does Employer have any Employees that reside in Massachusetts? Yes No

The Massachusetts Health Care Reform Act requires Employers to provide, or contract with another entity to provide, a written statement to individuals residing in Massachusetts who had "creditable coverage" at any time during the prior calendar year through the Employer's group health plan and to file a separate electronic report to the Massachusetts Department of Revenue verifying information in the individual written statements.

- a. Does the Employer direct Claim Administrator to provide written statements of creditable coverage to its Covered Employees who reside, or have enrolled dependents who reside, in Massachusetts and file electronic reports to the Massachusetts Department of Revenue in a manner consistent with the requirements under the Massachusetts Health Care Reform Act? Such written statements and electronic reporting shall be based on information provided to the Claim Administrator by the Employer and coverage under the Plan during the term of the Administrative Services Agreement. The Employer hereby certifies that, to the best of its knowledge, such coverage under the Plan is "creditable coverage" in accordance with the Massachusetts Health Care Reform Act. The Employer acknowledges that the Claim Administrator is not responsible for verifying nor ensuring compliance with any tax and/or legal requirements related to this service. The Employer or its Covered Employees should seek advice from their legal or tax advisors as necessary.

Yes No

- b. If no: The 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.

3. Case Management Program: Yes No

If Yes: The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons in accordance with the provisions of the Administrative Services Agreement to which this ASO BPA is attached and the Employer's plan document.

4. Employer acknowledges and agrees to utilize Claim Administrator’s standard list of services and supplies for which pre-notification or preauthorization is required: Yes No If no, Employer authorizes Claim Administrator to post Employer’s pre-notification or preauthorization requirements on Claim Administrator’s Website: Yes No

5. Essential Health Benefits (“EHB”) Election:

Employer elects EHBs based on the following:

1. EHBs based on a HCSC state benchmark:

- Illinois Oklahoma
- Montana Texas
- New Mexico

2. EHBs based on benchmark of a state other than IL, MT, NM, OK and TX

If so, indicate the state's benchmark that Employer elects: _____

3. Other EHB, as determined by Employer.

In the absence of an affirmative selection by Employer of its EHBs, then Employer is deemed to have elected the EHBs based on the Texas benchmark plan.

6. Employer contribution:

Employer Contribution – Medical	Employer Contribution – Dental
_____ % of Employee’s premium, or \$_____	_____ % of Employee’s premium, or \$_____
_____ % of Dependent’s premium, or \$_____	_____ % of Dependent’s premium, or \$_____

Comments: _____

7. This ASO Benefit Program Application (ASO BPA) is incorporated into and made a part of the Administrative Services Agreement with both such documents to be referred to collectively as the “Agreement” unless specified otherwise.

Producer/Consultant Compensation

The Employer acknowledges that if any producer/consultant acts on its behalf for purposes of purchasing services in connection with the Employer’s Plan under the Administrative Services Agreement to which this ASO BPA is attached, the Claim Administrator may pay the Employer’s producer/consultant a commission and/or other compensation in connection with such services under the Agreement. If the Employer desires additional information regarding commissions and/or other compensation paid the producer/consultant by the Claim Administrator in connection with services under the Agreement, the Employer should contact its producer/consultant.

ADDITIONAL PROVISIONS:

A. Grandfathered Health Plans: Employer shall provide Claim Administrator with written notice prior to renewal (and during the plan year, at least 60 days advance written notice) of any changes that would cause any benefit package of its group health plan(s) (each hereafter a “plan”) to lose its status as a “grandfathered health plan” under 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 Claim Administrator to the terms and conditions of administrative services. In no event shall Claim Administrator be responsible for any legal, tax or other ramifications related to any plan’s grandfathered health plan status 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 into and become part of the BPA and Agreement, and Employer represents and warrants that such Form is true, complete and accurate.

B. Retiree Only Plans, Excepted Benefits and/or Self-Insured Nonfederal Governmental Plans: If the BPA includes any retiree only plans, excepted benefits and/or self-insured nonfederal governmental plans (with an exemption election), then Employer represents and warrants that one 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 Claim Administrator to the terms and conditions of administrative services. In no event shall Claim Administrator be responsible for any legal, tax or other ramifications related to any plan’s exempt plan status or any representation regarding any plan’s exempt plan status.

- C. Employer shall indemnify and hold harmless Claim Administrator 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 Claim Administrator in connection with (a) any plan’s grandfathered health plan status, (b) any plan’s exempt plan status, (c) any plan’s design (including but not limited to any directions, actions and interpretations of the Employer), (d) any provision of inaccurate information, (e) the SBC, and/or (f) selection of Employer's EHB benchmark for the purpose of ACA. Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of administrative services.

The provisions of paragraphs A-C (directly above) shall be in addition to (and do not take the place of) the other terms and conditions of administrative services between the parties.

I UNDERSTAND AND AGREE THAT:

1. **Only complete for new accounts:** Receipt by HCSC of the advance administrative fee (where applicable), in the amount of \$_____, and completed enrollment forms does not constitute approval and acceptance by the HCSC Home Office.
2. HCSC will report the value of all remuneration by HCSC to ERISA plans with 100 or more participants for use in preparation of ERISA Form 5500 schedules. Reporting will also be provided upon request to non-ERISA plans or plans with fewer than 100 participants. Reporting will include base commissions, bonuses, incentives, or other forms of remuneration for which your Producer/consultant is eligible for the sale or renewal of self-funded and/or insured products.

Sales Representative

Signature of Authorized Purchaser

District Phone & FAX Numbers

Title

Producer Representative

Date

Producer Firm

Signature of HCSC Vice President

Producer Address

Signature Underwriting

Producer Phone & FAX Numbers

Producer Email Address

Tax I.D. No.

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 shall be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed 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 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.

From time to time, HCSC pays indemnification or advances expenses to a director, officer, employee or agent 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: _____

Dated this _____ day of _____
Month Year