AGENDA ITEM
A13

AGENDA PLACEMENT FORM

(Submission Deadline – Monday, 5:00 PM before Regular Court Meetings)

Date: September 30, 2024

Meeting Date: October 15, 2024

Submitted By: Randy Gillespie

Department: Personnel

Signature of Elected Official/Department Head:

Randy Gillespie

Court Decision:
This section to be completed by County Judge's Office

Johnson County ★ APPROVED ★ Commissioners Court

10-15-24

Description:

Discuss and Take Any Appropriate Action Necessary for 2025 Benefit Plan Year.

a. Application BCBS TX Large Group 10-1-2024

b. Benefit Program Application to Admin Services Only Group Acct 10-1-2024

c. Application and Policy Schedule Stop Loss 10-1-2024

d. Pharmacy Benefit Manager Fee Schedule Addendum 10-1-2024

e. Benefit Program Application Large Group 1-1-2025

f. Benefit Program Application Administrative Services 1-1-2025

g. Application and Policy Stop Loss 1-1-2025

(May attach additional sheets if necessary)

Person to Present: Julie Rickman, AVP, Client Service, Team Lead

(Presenter must be present for the item unless the item is on the Consent Agenda)

Supporting Documentation: (check one) ☐ PUBLIC ☐ CONFIDENTIAL

(PUBLIC documentation may be made available to the public prior to the Meeting)

Estimated Length of Presentation: 15 minutes

Session Requested: (check one)

☑ Action Item ☐ Consent ☐ Workshop ☐ Executive ☐ Other _____

Check All Departments That Have Been Notified:

☐ County Attorney ☐ IT ☐ Purchasing ☐ Auditor

☐ Personnel ☐ Public Works ☐ Facilities Management

Other Department/Official (list) _____

Please List All External Persons Who Need a Copy of Signed Documents In Your Submission Email

BlueCross BlueShield of Texas

1001 E. Lookout Drive
Richardson, Texas 75082

BENEFIT PROGRAM APPLICATION ("BPA")

Blue Cross and Blue Shield of Texas (herein called "BCBSTX")

LARGE GROUP PLANS

Account Status: ☐ New ☒ Existing with Changes

Off Cycle Change: ☐ Yes ☒ No ☐ Former BCBSTX ASO converting to fully insured

Account Number (6-digits): 369192 Group Number(s): 370072, 396140

Policy Effective Date (month/day/year): 10/01/2024 Policy Anniversary Date (month/day/year): 01/01/2025

Legal Account Name: County of Johnson
(Specify the Employer or the employee trust applying for coverage. An employee benefit plan may not be named)

☒ **NO CHANGES** **GROUP INFORMATION**

Employer Identification Number ("EIN"): 756001030

Standard Industry Code ("SIC"): 9111 Nature of Business: Non-Federal Govermental Agency / County

Primary (Mailing) Address: 2 N. Main St. Room 215

City: Cleburne State: TX Zip: 76033

Administrative Contact: Title:
Randy Gillespie Personnel Director
Phone: 817-556-6194 Fax: 817-556-6899 Email: randyg@johnsoncountytx.org

Blue Access for Employers℠ ("BAE℠") Contact: Title:
Darla Medford HR Generalist/ Benefit Coordinator
The BAE Contact is an Employee of the account who is authorized by the Employer to access and maintain the account in BAE.

Phone: 817-556-6349 Fax: 817-556-6899 Email: dmedford@johnsoncountytx.org

Administrative Contact (if different from Primary): Title:
Darla Medford HR Generalist / Benefits Coordinator
Phone: 817-556-6349 Fax: 817-556-6899 Email: dmedford@johnsoncountytx.org

Physical Address (if different from Primary - required): 2 N. Main St. Room 215
City: Cleburne State: TX Zip: 76033

Contact: Darla Medford

Billing Address (if different from Primary): 2 N. main St. Room 215

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Life, Disability, Specified Disease, Accident, Hospital Indemnity and Vision insurance is underwritten by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Dearborn Life Insurance Company is an independent Blue Cross and Blue Shield licensee. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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City: Cleburne State: TX Zip: 76033

Billing Contact: Laura Baxter Title: Personnel Assistant
Phone: 817-556-6162 Fax: 817-556-6899 Email: laurab@johnsoncountytx.com

Do you cover any wholly owned subsidiary or affiliated companies? ☒ Yes ☐ No If yes, please list below:
Subsidiary Companies to be covered (if more than one, list within the Additional Provisions):
Central Appraisal District

Subsidiary Address: 109 N Main St

City: Cleburne State: TX Zip: 76033

Contact: Darla Medford Title: HR Generalist / Benefits Coordinator

Phone: 817-556-6349 Fax: 817-556-6899 Email: dmedford@johnsoncountytx.org

Affiliated Companies to be covered (if more than one, list within the Additional Provisions):

_____

Location(s): _____

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 your ERISA Plan Year* a period of 12 months beginning on the Anniversary Date specified above? ☐Yes ☐No

If no, please specify your ERISA Plan Year (month/day/year): Beginning Date ____/____/____ End Date ____/____/____

ERISA Plan Administrator*: _____

Plan Administrator's Address: _____

If you maintain that ERISA is not applicable to your 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
☐ Other; please specify: _____

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

If no, please specify your ERISA Plan Year (month/day/year): Beginning Date ____/____/____ End Date ____/____/____

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

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☒ NO CHANGES **PRODUCER OF RECORD INFORMATION**

1. *Producer/Agency** name to whom commissions are to be paid: Holmes Murphy & Associates LLC
Producer Number of ☐ Producer or ☒ Agency: 000013905
Street Address: 12712 Park Central Drive, Suite 100
City: Dallas Zip: 75251
Phone: 800-882-5949 Fax: _____
Email: jrickman@holmesmurphy.com
Is Producer/Agency appointed with BCBSTX? ☒ Yes ☐ No Affiliated with General Agent? ☐ Yes ☒ No
Commissions:
☒ PCPM $0 Does a Monthly Cap Apply ☐ Yes ☐ No $ (If cap is annual, divide by twelve)
☐ Flat $ Does a Monthly Cap Apply ☐ Yes ☐ No $ (If cap is annual, divide by twelve)
ADDITIONAL COMMISSIONS:

2. *Producer/Agency** name to whom commissions are to be paid: _____
Producer Number of ☐ Producer or ☐ Agency: _____
Street Address: _____
City: _____ Zip: _____
Phone: _____ Fax: _____
Email: _____
Is Producer/Agency appointed with BCBSTX? ☐Yes ☐No Affiliated with General Agent? ☐ Yes ☐ No
Commissions:
☐ PCPM $ Does a Monthly Cap Apply ☐ Yes ☐ No $ (If cap is annual, divide by twelve)
☐ Flat $ Does a Monthly Cap Apply ☐ Yes ☐ No $ (If cap is annual, divide by twelve)
ADDITIONAL COMMISSIONS:
If commission split, designate percentage for each producer/agency **Note**: total commissions paid must equal one hundred percent (100%)
Producer/Agency 1: _____% Producer/Agency 2: _____%

3. Writing Producer's Name (please print):
Producer Number: _____ Phone: _____ Email: _____
Writing Producer's Signature: _____ Date: _____

*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 BCBSTX.

☒ NO CHANGES **SCHEDULE OF ELIGIBILITY**

1. **Standard Eligibility Provisions:** Eligible Employee/Subscriber means an Employee who works on a full-time basis, who usually works at least thirty (30) hours a week, and who otherwise meets the Participation Criteria established by an Employer. The term includes a sole proprietor, a partner, and an independent contractor, if the individual is included as an Employee under a Health Benefit Plan of a large Employer regardless of the number of hours the sole proprietor, partner, or independent contractor works weekly, but only if the plan includes at least two (2) other Eligible Employees who work on a full-time basis and who usually work at least thirty (30) hours a week. Participation Criteria means any criteria or rules established by a large Employer to determine the Employees who are eligible for enrollment or continued enrollment under the terms of a Health Benefit Plan. The Participation Criteria may not be based on Health Status Related Factors.

(HMO only) the Eligible Subscriber must reside, live, or work in the Service Area.

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2. **Other Eligibility Provisions (check all that apply):**

☒ Retiree of the Employer.
☐ Part-time Employee of the Employer.
☐ Other: _____

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

Domestic Partners covered: ☐ Yes ☒ No
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. An Employer may only elect or change Domestic Partner Coverage on the Policy Effective Date or Policy Anniversary Date.

Continuation coverage for Domestic Partners: If Employer elects coverage for Domestic Partners, a Domestic Partner is eligible for continuation coverage under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) if an eligible Employee elects COBRA coverage. Employer may also elect whether to provide continuation 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 an Employee's election of COBRA.
☐ No, Employer does not elect to offer continuation coverage to Domestic Partners on an independent basis from an Employee's election of COBRA (Domestic Partners are not independently eligible for continuation coverage)
☐ Other: _____

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

If a person is added to the Policy and it is later determined that the Policyholder reported a coverage date earlier than what would apply to the Employee or Dependent, 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.

What is the effective date for a newly eligible person who becomes effective after the Employer's initial enrollment? (No effective date may exceed ninety-one (91) calendar days from the date that an individual becomes eligible for coverage, unless permitted by applicable law.)

☐ 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 1st day (standard is first (1st) or fifteenth (15th)) of the month following sixty (60) days of employment.
☐ The _____ day (standard is first (1st) or fifteenth (15th)) of the month following select one month(s) of employment.

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 (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

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☐ 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: Part- time employee moving to full-time, benefits will start the 1st of the following month as will as long as they have completed their 60 days of employement

(HMO only) What is the effective date of coverage for a Newly Eligible Employee who becomes effective after the Employer's initial enrollment date? (No effective date may exceed ninety-one (91) calendar days from the date that an individual becomes eligible for coverage, unless permitted by applicable law.)

☐ The first (1st) day of the month following the date of employment (date of hire).
☒ The first (1st) day of the month following sixty (60) days of employment.
☐ The first (1st) day of the month following select one month(s) of employment.

4. **Are there multiple new hire Waiting Periods?** ☐ Yes ☒ No
If yes, attach eligibility and contribution details for each section.

Is the Waiting Period requirement to be waived on initial group enrollment?
Health ☐ Yes ☐ No ☐ N/A Dental ☒ Yes ☐ No ☐ N/A

5. **Annual Open Enrollment:** For Health and Dental Plans only, an Eligible Person, 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. Such person's individual coverage date, family coverage date and/or Dependent's coverage date will be the Policy Anniversary Date following the Open Enrollment Period, provided the application is dated and signed prior to that date.

The Open Enrollment Period will be held during a thirty-one (31) day period prior to the Policy Anniversary Date of the program. Specify start of annual Open Enrollment Period: _____.

6. **The minimum standard limiting age for covered Dependent children is twenty-six (26) years.** Hereafter, a Dependent Child, Child or Children means a natural child, a stepchild, a medical support order child, an eligible foster child, an adopted child (including a child for whom the Employee or their spouse is a party in a suit in which the adoption of the child is sought) 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. To be eligible for coverage, a child of an Employee's child must also be dependent upon Employee for federal income tax purposes at the time application for coverage is made.

7. **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. 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 certification review, forms, and previous medical certification approvals.

a. ☒ Disabled Dependent Administration will follow **standard rules.**

A disabled Dependent is eligible to add or continue coverage beyond the limiting age of twenty-six (26). Certification Review is administered by BCBSTX; a Disabled Dependent Certification Form must be submitted to BCBSTX.

(HMO only) Proof of incapacity and dependency may be required within thirty-one (31) days of the child's attainment of the limiting age. Subsequent recertification may occur annually, as required.

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b. ☐ Disabled Dependent Administration will follow **custom rules**. Please make the following selections:

Age: A disabled Dependent is eligible to add or continue coverage beyond the limiting age of twenty-six (26).

Certification Review: Please select one (1) option regarding administration of Certification Review.

☐ Certification Review is administered by BCBSTX; a Disabled Dependent Certification Form must be submitted to BCBSTX.

(HMO only) Proof of incapacity and dependency may be required within thirty-one (31) days of the child's attainment of the limiting age. Subsequent recertification may occur annually, as required.

☐ Certification Review is administered by the Employer; there are no Disabled Dependent Certification Form requirements.

If Certification Review is administered by BCBSTX, please select one (1) option regarding forms:

☐ BCBSTX's Disabled Dependent Certification Form will be utilized.

☐ A custom/other Disabled Dependent Certification Form will be utilized.

If Certification Review is administered by BCBSTX, 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.

CURRENT ELIGIBILITY INFORMATION – NEW BUSINESS OR ADD ON ONLY

Total number of Employees/Subscribers:

1. On payroll _____
2. On COBRA continuation coverage _____
3. With retiree coverage (if applicable) _____
4. Who work part-time _____
5. Serving the new hire 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 (HMO only) LEGISLATIVE ELECTIONS

The following mandated benefit offers are made by HMO in compliance with Texas regulations. Please mark your acceptance or declination. Acceptance may result in a rate adjustment.

In Vitro Fertilization Services

☐ **Accept** – If accepted, benefits for In Vitro Fertilization Services will be provided to the same extent as benefits provided for other pregnancy related procedures. **(Note: If selected, an additional charge will be added to your rates.)**

☐ **Decline** – If declined, no benefits are available.

Speech and Hearing Services

☐ **Accept** – Benefits are paid same as any other illness.

☐ **Decline** – If declined, medically necessary speech therapy is covered on an outpatient basis only. Hearing aid benefit is limited to one (1) hearing aid per ear every thirty-six (36) months.

Development Delay – Certain therapies for children with developmental delays are already included in the HMO plans.

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☒ **NO CHANGES** **(Non-HMO only) LEGISLATIVE ELECTIONS**

The following mandated benefit offers are made in compliance with Texas regulations. Please mark your acceptance or declination.

In Vitro Fertilization Services: Benefits for Medical-Surgical Expense incurred for in vitro fertilization procedures will be the same as for maternity care, provided specific requirements are met.

☐ **Accept** – If accepted, benefits for In Vitro Fertilization Services will be provided to the same extent as benefits provided for other pregnancy related procedures. **(Note: If selected an additional charge will be added to your rates.)**

☐ **Decline** – If declined, no benefits are available for these services.

Speech and Hearing Services: Benefits are available for the services of a physician or other provider to restore loss of or correct an impaired speech or hearing function. This benefit includes coverage for hearing aids.

☐ **Accept** – If accepted, benefits are available for medically necessary services to restore loss of or correct an impaired speech or hearing function, with no benefit maximum on hearing aids.

☐ **Decline** – If declined, benefits are available for medically necessary services to restore loss of or correct an impaired speech or hearing function; however, benefits for hearing aids are limited to one (1) hearing aid per ear every thirty-six (36) months.

Development Delay – Certain therapies for children with developmental delays are already included in the Non-HMO plans.

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☐ **NO CHANGES**

LINES OF BUSINESS
(Check all applicable products)

Managed Health Care Coverage:

☐ Single Option: PPO Plan _____

☐ Multiple Plan Option:

Select up to four (4) plans. All plans may be PPO or HSA plans. If an HMO is selected, a PPO must also be selected.

Plan 1 _____ **Select Product**
Plan 2 _____ **Select Product**
Plan 3 _____ **Select Product**
Plan 4 _____ **Select Product**

If an HMO plan is selected, indicate additional election(s) below (if applicable):

Additional Benefit Options:

☐ Prescription Drug Program _____
☐ Inpatient Mental Health Care (IPMH) Select IPMH
☐ Durable Medical Equipment Select DME

See **HMO Legislative Elections** for In-Vitro Fertilization and Speech and Hearing Services options.

One hundred percent (100%) of Eligible Employees must reside, live, or work in the service area. The HMO service area includes all counties in Texas.

***If an HMO health plan is selected, please complete the HMO Non-Network Plan Certification (item 2) in the OTHER PROVISIONS section of this BPA.**

If HCA is selected, the HCA BPA with HCA Administrative Services Agreement must be completed, signed, and submitted.

Preferred HSA Vendor: **Select Vendor**
If HealthEquity, Inc. is selected, BCBSTX to send HSA enrollment to HealthEquity, Inc.: ☐ Yes ☐ No
Non-Preferred Vendor: _____

Preferred FSA Vendor: **Select Vendor**
Non-Preferred Vendor: _____

Preferred Health Reimbursement Account (HRA) Vendor: **Select Vendor**
Non-Preferred 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.

☐ **Blue Directions℠** If selected, the Blue Directions Addendum is attached and made part of the Policy

Health Care Management Services:

☐ Wellbeing Management (WBM)

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In-Hospital Indemnity Plan:

☐ IHI

DENTAL BENEFIT PLANS:

Voluntary Group Dental

☐ Plan _____

☒ Dual Option: Plan 1 PDENT Dental High Plan Plan 2 PDENT Dental Low Plan

Employer-Paid Dental

☐ Plan _____

☐ Dual Option: Plan 1 _____ Plan 2 _____

BlueMax Advantage:

☐ Graduated dental benefit max

ANCILLARY COVERAGE:

☒ **Life, Disability, Specified Disease, Accident, Hospital Indemnity or Vision:** If checked, attach separate application for those coverages

COMMENTS: _____

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PREMIUM RATES						
	For Internal Use Only - Blue Star℠ Ben.Agree#: BA0004 Dental High Plan	*For Internal Use Only - Blue Star Ben.Agree#:* BA0005 Dental Low Plan	*For Internal Use Only - Blue Star Ben.Agree#:* _____ _____	*For Internal Use Only - Blue Star Ben.Agree#:* _____ _____	*For Internal Use Only - Blue Star Ben.Agree#:* _____ _____	*For Internal Use Only - Blue Star Ben.Agree#:* _____ S _____
1. Employee only:	$34.70	$8.73	$_____	$_____	$_____	$_____
2. Employee plus one (1) dependent (i.e., Employee plus one (1) spouse or one (1) child):	$_____	$_____	$_____	$_____	$_____	$_____
3. Employee plus two (2) or more dependents:	$_____	$_____	$_____	$_____	$_____	$_____
4. Employee plus Spouse:	$69.35	$18.56	$_____	$_____	$_____	$_____
5. Employee plus Child(ren) (i.e., Employee plus one (1) or more children):	$74.41	$20.18	$_____	$_____	$_____	$_____
6. Employee plus Family / Family:	$114.36	$28.97	$_____	$_____	$_____	$_____
7. Other: _____	$_____	$_____	$_____	$_____	$_____	$_____
Single Tier Rate structure - Complete item 1.						
Two Tier Rate structure - Complete items 1. and 6.						
Three Tier Rate structure - Complete items 1., 2., and 3.						
Four Tier Rate Structure - Complete items 1., 4., 5., and 6.						
Indicate "N/A" in any rate field that does not apply.						
Medicare Eligible Rates (When BCBSTX is Secondary Payer)						
Single Coverage:	$_____	$_____	$_____	$_____	$_____	$_____
Family Coverage:	$_____	$_____	$_____	$_____	$_____	$_____

COMMENTS: _____

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HMO PROGRAM
☐ **Yes** ☒ **No**

Account Status: ☐ New Group ☐ Existing Group

Choose One: ☐ Blue Premier℠ HMO ☐ Blue Premier Access℠ HMO ☐ Blue Essentials℠ HMO

Physician Service Charges:
_____% of Claim Payments; $_____ per enrollee per month for health Claim Payments; **or** ☐ N/A

☒ **NO CHANGES** **FUNDING / CONTRIBUTION**

FUNDING ARRANGEMENT:

☒ Premium – Prospective

☐ **(Non-HMO only)** Premium – Prospective Retention (Retro Contingent)

☐ **(Non-HMO only)** Alternative Funding Minimum Premium Program – Prospective Minimum Premium (Retro Contingent). The standard premium and rate information does not apply to alternative funding programs. All information regarding premiums and the payments thereof for alternative funding programs can be found in the mutually agreed upon alternative funding agreement between the Employer and BCBSTX.

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 Participants 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 Participant's effective date falls on the sixteenth (16th) day through the end of the month.

2. The contribution of premium to be paid by the Employer is:

PRODUCT	Employee Only	Employee/Child(ren)	Employee/Spouse	Employee/Family
HEALTH				
Plan 1	% or $	% or $	% or $	% or $
Plan 2	% or $	% or $	% or $	% or $
Plan 3	% or $	% or $	% or $	% or $
Plan 4	% or $	% or $	% or $	% or $
DENTAL				
Plan 1	% or $	% or $	% or $	% or $
Plan 2	% or $	% or $	% or $	% or $

3. **(HMO only)** Grace Period: thirty (30) days – standard

4. Prior written notification by BCBSTX to Employer for change of premium rates is sixty (60) days

5. Additional Information/Comments: _____

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☒ NO CHANGES — BILLING SPECIFICATIONS

Employees Listed: ☒ alphabetically ☐ by location
If by location, list locations including location numbers if applicable: _____

Sort by: ☐ Unique Identification Number **(standard)**
☒ Social Security Number

Billing format:
(complete only if special billing requirements are needed)

- ☐ Benefit Agreement
- ☐ Also, Page Break
- ☐ Categories
- ☐ Multiple Billing Profiles

Explanation: _____

Premium Delay:
(Underwriter approval required for options other than zero (0) day delay)

- ☒ Zero (0) day delay **(standard)**
- ☐ Thirty (30) day delay
- ☐ Sixty (60) day delay
- ☐ Ninety (90) day delay

☒ NO CHANGES — ID CARD DELIVERY

Mail ID Cards to:

- ☐ Account
- ☒ Member's home **(standard)**

Note: if an HMO plan is selected, HMO ID cards must be mailed to the Member's home

☐ NO CHANGES — OTHER PROVISIONS

1. **Electronic Issuance**: Delivery of insurance documents, including but not limited to the GAD, BPA, Benefit Booklet, SBC and other required forms and amendments thereto, will be delivered via an electronic file or access to an electronic file to the Employer for delivery of applicable documents to each Employee. The Employer agrees that it is solely responsible for providing each Employee access to the most current version of any E-file Benefit Booklet, amendment, or other revised form provided by BCBSTX, or to provide a paper copy of the same to an Employee upon request. The Employer is solely responsible and holds BCBSTX harmless from any misuse of the E-file provided by BCBSTX. You can request paper delivery of insurance documents by opting-out below. You may also go back to paper delivery at any time with no penalty. To change your preferences, contact your Account Executive. Your documents can be viewed or printed using your computer or mobile device that supports mobile browsing. If the method to access electronic files is revised, BCBSTX will notify you and give an opportunity to request paper delivery. Notice of cancellation or termination of a policy will be delivered both electronically and in paper form.

   ☐ Opt-Out – Employer declines to receive electronic versions of insurance documents.

2. **(HMO only) HMO Non-Network Plan Certification:** The Texas Insurance Code mandates HMOs whose network-based delivery system of coverage is the only health benefit coverage being offered under an Employer's health benefit plan must offer all Eligible Subscribers the opportunity to obtain other health coverage through a non-network plan at the time of enrollment and at least annually.

   The non-network coverage required by law may be provided through a point-of-service contract, a preferred provider benefit plan, or any coverage arrangement that allows an Employee to access services outside the HMO's or limited provider network's delivery network. New and renewing groups who refuse to offer or certify that they offered a non-network plan concurrent with the HMO-only will not be allowed to purchase or renew coverage through BCBSTX. To comply with the provisions of this mandate, BCBSTX requests Employer groups certify a non-network plan will be offered to Eligible Subscribers.

   Describe Non-Network Product Offered: _____
   Authorized Company Official's Initials: _____

3. **EHB Election:** Employer elects EHBs based on the Texas benchmark.

4. This BPA is incorporated into and made a part of the Policy entered into and agreed upon by BCBSTX and the account.

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

6. **Reimbursement:** It is understood and agreed that in the event BCBSTX makes a recovery on a third-party liability claim, BCBSTX 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.

7. **Third-Party Recovery Vendors and Law Firms Provisions (other than Reimbursement Services)**: BCBSTX 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.

8. **Massachusetts Health Care Reform Act:** If elected below, BCBSTX will provide required written statements of Minimum Creditable Coverage ("MCC") to Participants residing in Massachusetts and submit applicable electronic reporting to the Massachusetts Department of Revenue. Information transmitted will be exclusively based on information provided to BCBSTX by Employer and coverage under the Plan(s) during the term of the Contract. By electing to have BCBSTX 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 BCBSTX is not responsible for verifying nor ensuring compliance with any tax and/or legal requirements related to this service. Employer or its Participants 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 BCBSTX 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.

9. ☐ **Medical and Ancillary Package Pricing:** The rates shown in this Contract 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 Policy Effective Date. If any of the qualifying ancillary coverage (BlueCare Dental, Basic Life, Short-Term Disability, Long-Term Disability, Accident, Critical Illness, Hospital Indemnity and/or Vision product(s)) lapses during this twelve (12) month period, BCBSTX 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 BCBSTX 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 BCBSTX to the terms and conditions of coverage. In no event shall BCBSTX 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 BPA and Group Policy, and Employer represents and warrants that such Form is true, complete, and accurate. If Employer fails to timely provide BCBSTX with any requested grandfathered health plan information, BCBSTX 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 the BPA includes any retiree only plans and/or excepted benefits, then Employer represents and warrants that one (1) or more such plans is not subject to some or all of the provisions

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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 BCBSTX to the terms and conditions of coverage. In no event shall BCBSTX 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. Employer shall indemnify and hold harmless BCBSTX 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 inquiries or actions, settlements or judgments brought or asserted against BCBSTX in connection with (a) any plan's grandfathered health plan status, (b) any plan's exempt plan status, (c) any directions, actions and interpretations of the Employer, and/or (d) any provision of inaccurate information, and/or (f) Employer's selection of Essential Health Benefit ("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 coverage.

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 coverage and/or administrative services between the parties.

Notwithstanding anything in the Policy or Renewal(s) to the contrary, BCBSTX reserves the right to revise our charge for the cost of coverage (premium or other amounts) at any time if any local, state or federal legislation, regulation, rule or guidance (or amendment or clarification thereto) is enacted or becomes effective/implemented, which would require BCBSTX 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).

Renewals Only: (For the purposes of this Policy, the term "existing BPA" includes, if applicable, the initial Schedule of Specifications and/or Group Agreement signed by the Employer, and any subsequent Schedules of Specifications and/or Group Agreements and amendments thereto.) If this BPA is blank, it is intentional, and this BPA is an addendum to the existing BPA. In such case, all terms of the existing BPA as amended from time to time shall remain in force and effect. However, beginning with the Employer's first renewal date on or after September 23, 2010, the provisions of paragraphs A-C (above) shall be part of (and be in addition to) the terms of the existing BPA as amended from time to time.

Summary of Benefits and Coverage ("SBC"): The SBC Addendum is attached and made a part of the Policy. BCBSTX will create the SBC (only for benefits BCBSTX insures under the Policy) and provide the SBC to the Employer in electronic format. If the Employer approves of the content, Employer will then distribute the SBC to participants and beneficiaries (or hire a third party to distribute) as required by law. If the Employer would like changes to the SBC, it will promptly notify BCBSTX. BCBSTX will also distribute the SBC to participants and beneficiaries via regular hardcopy mail or electronically in response to occasional requests received directly from individuals. All other distribution is the responsibility of the Employer.

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EMPLOYER STATEMENTS:

1. BCBSTX 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 policy based on the enrolled participation and Employer contribution levels;
   b) After the policy 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 if the fifty percent (50%) minimum Employer contribution is not met and/or less than seventy-five percent (75%) of Eligible Employees are enrolled for coverage for six (6) consecutive months.

   BCBSTX reserves the right to change premium rates when a substantial change occurs in the number or composition of Subscribers covered. A substantial change will be deemed to have occurred when the number of Employees/Subscribers 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.

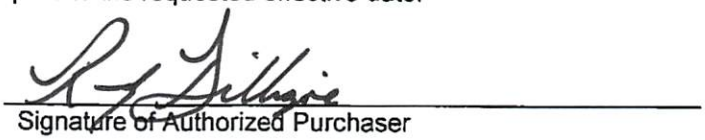
   Employer will promptly notify BCBSTX of any change in participation and Employer contribution.

2. 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 Policy(ies), this BPA or enrollment material in any manner or to adjust any claims for benefits under the Policy(ies).

3. BCBSTX will report the value of all remuneration by BCBSTX to ERISA plans with one hundred (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 one hundred (100) participants. Reporting will include base commissions, bonuses, incentives, or other forms of remuneration for which your agent/consultant is eligible for the sale or renewal of self-funded and/or insured products.

4. 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 Policy into which this BPA shall be incorporated at the time of acceptance by BCBSTX. Upon acceptance, BCBSTX shall issue a Contract to the Employer and the Employer shall be referred to as the "Employer or Policyholder" (Non-HMO) and "Group" (HMO) in the Contract.

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

Amy Westendorf	
Authorized BCBSTX Representative	Signature of Authorized Purchaser
Account Executive	Personnel Director
Title	Title
	10/15/2024
Date	Date
Agent Representative (if applicable)	

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PROXY (OPTIONAL)

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 Randy Gillespie

Personnel Director

Signature and Title ➡

Group Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Dated this 15th day of October 2024
Month Year

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BlueCross BlueShield of Texas

Consumer Choice Plan Disclosure Statement

This health plan does not include the same level of benefits required in other plans.

This HMO plan is a consumer choice plan. This plan doesn't include the same level of benefits that are in Texas health plans known as state-mandated plans. This plan does include all health benefits required by the Affordable Care Act.

To see all benefits offered by this plan, go to the plan's "Summary of Benefits and Coverage."

Benefit/coverage:	This plan:	A health plan with required benefits (state-mandated plan):
Deductible The amount you pay for care before the plan begins to share the cost.	Has a deductible.	Has no deductibles for participating provider care.
Out-of-Pocket Costs The amount you pay when you receive covered services, up to a calendar year maximum.	Includes out-of-pocket costs that meet federal requirements but may sometimes be more than in a state-mandated plan.	A copay must be less than 50% of the total cost of the service. Annual out-of-pocket costs must be capped at 200% of your annual premium cost if you alert the plan.
Habilitative and Rehabilitative Care Care that helps you improve skills for daily living.	Includes a limit on the number of visits per year for speech therapy, occupational therapy, physical therapy and chiropractic care. Limits do not apply for the treatment of acquired brain injury and autism spectrum disorder.	Has no limits on the amount of care if it is needed for medical reasons.
Home Health Services	Includes a limit for home health services.	Has no limits on home health services.
Therapies for Children with Developmental Delays	Does not cover therapies for treatment of developmental delay in children	Covers certain development delay therapies for children with developmental delay, up to age three.

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BlueCross BlueShield
of Texas

If you want a plan with all required benefits:

We also offer a state-mandated plan that includes all required benefits. This plan is not on Healthcare.gov and does not allow you to get help with premiums and out-of-pocket costs. To learn more about this plan, call 1-877-299-2377or visit https://www.bcbstx.com/shop-plans-and-products.

By signing this form, you acknowledge the following:

- I understand the consumer choice plan I am applying for does not provide the same level of coverage required in other Texas health plans (state-mandated plans).
- I understand I can get more information about consumer choice plans from the Texas Department of Insurance's website, https://www.tdi.texas.gov/consumer/consumerchoice.html, or by calling the Consumer Help Line at 1-800-252-3439.

Do not sign this document if you don't understand it.
No firme este documento si no lo comprende.

Signature of Applicant 10/15/2024 **Date**

Randy Gillespie
Name of Applicant (print name)

Johnson County
Name of Business, if applicable

2 N. Main Street
Address

Cleburne Texas 76033
City **State** **Zip**

HMO must give you a copy of this statement upon request.

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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, an Independent Licensee of the Blue Cross and Blue Shield Association, hereinafter referred to as the "Claim Administrator" or "BCBSTX"

Group Status: Renewing ASO Account

Employer Account Number (6-digits): 369192 Group Number(s): 369192. 369193, 369194, 370072, 396140

Section Number(s): _____

Legal Employer Name: County of Johnson

(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

Is your ERISA Plan Year* a period of 12 months beginning on the Effective Date of Coverage specified below? ☐Yes

If not, 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 from drop down ; if applicable, specify other: _____

Is your Non-ERISA Plan Year* a period of 12 months beginning on the Anniversary Date specified below? ☒Yes

If not, 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) 10 / 01 / 2024

Anniversary Date: (Month/Day/Year) 01 / 01 / 2025

Retiree-Only Plan(s) Identification:
For more information regarding Retiree-only plans, contact your Legal Advisor.

Do you have one or more Retiree-only plan(s)? ☐ Yes ☒ No

If yes, please provide Benefit Agreement number, or group and section numbers of the Retiree-only plan(s):

_____

Account Information	☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS	
Standard Industry Code (SIC): 9111	Employer Identification Number (EIN): 756001030	
Address: 2 N Main St., Room 215		
City: Cleburne	State: TX	ZIP: 76033-5500
Administrative Contact: Darla Medford	Title: HR Generalist / Benefits Coordinatior	
Email Address: dmedford@johnsoncountytx.org	Phone Number: 817-556-6349	Fax Number: 817-556-6899
☐ Mailing address is different from primary address		
Mailing Address: 2 N Main St., Room 215		
City: Cleburne	State: TX	ZIP: 76033-5500
Mailing Contact: Randy Gillespie	Title: Personnel Director	
Email Address: randyg@johnsoncountytx.org	Phone Number: 817-556-6149	Fax Number: 817-556-6899
☐ Billing address is different from primary address		
Billing Address: 2 N Main St., Room 215		

Proprietary and Confidential Information of Claim Administrator
Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator.

City: Cleburne | State: TX | ZIP: 76033-5500

Billing Contact: Laura Baxter | Title: Personnel Assistant

Email Address: laurab@johnsoncountytx.org | Phone Number: 817-556-6162 | Fax Number: 817-556-6899

Wholly Owned Subsidiaries to be covered: _____

Affiliated Companies to be covered: Central Appraisal District | Employer Identification Number (EIN): 751677972

(Affiliated Companies must be required or permitted to be aggregated per IRS Guidelines., Employer hereby confirms that Employer, Subsidiaries and Affiliates are treated as a single employer under Internal Revenue Code Section 414(b), or (c), or (m) or (o), or under applicable law.)

Subsidiary / Affiliate Address: 109 N Main St

City: Cleburne | State: TX | ZIP: 76033-5500

Subsidiary / Affiliate Contact: Darla Medford | Title: HR Generalist / Benefits Coordinatior

Email Address: dmedford@johnsoncountytx.org | Phone Number: 817-556-6349 | Fax Number: 817-556-6899

Blue Access for Employers℠ ("BAE℠") Contact: Darla Medford Coordinatior | Title: HR Generalist / Benefits

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

Email Address: dmedford@johnsoncountytx.org | Phone Number: 817-556-6349 | Fax Number: 817-556-6899

☒ The Employer or other company listed in this BPA is a is a public Entity or governmental agency/contractor

Producer of Record Information

☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

Effective: 10/01/2023

If applicable, the below-named producer(s) or agency(ies) is/are recognized as the Employer's Producer of Record (POR) to act as a representative in negotiations with and to receive commissions from BCBSTX, or Claim Administrator's corporate subsidiaries, as applicable, for procuring Claim Administrator's claims administration services for Employer's employee benefit program(s). 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/Consultant Compensation:

The Employer acknowledges that if its POR 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 POR a commission and/or other compensation in connection with such services under the Administrative Services Agreement. If the Employer desires additional information regarding commissions and/or other compensation paid to the POR by the Claim Administrator in connection with services under the Administrative Services Agreement, the Employer should contact its POR.

Producer or Agency to whom commissions are to be paid*: Holmes Murphy & Associates LLC

Texas Producer #: 000013905 | NPN: 0000765524

Address: 12712 Park Central Drive, Suite 100

City: Dallas | State: TX | ZIP: 75251

Phone: 800-882-5949 | Fax: _____ | Email: jrickman@holmesmurphy.com

Is Producer/Agency appointed with BCBSTX 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*:** _____

Texas Producer #: (nine digits)

NPN: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____ Email: _____

Is Producer/Agency appointed with BCBSTX in Texas? ☐ Yes ☐ No General Agent? ☐ Yes ☐ No

Commissions:

☒ PCPM $0 Does a Monthly Cap Apply ☐ Yes ☐ No $_____ (If cap is annual, divide by twelve)

☐ Flat $_____ Does a Monthly Cap Apply ☐ Yes ☐ No $_____ (If cap is annual, divide by twelve)

☐ Percentage of Stop Loss:_____%

ADDITIONAL COMMISSIONS: _____

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 BCBSTX 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: Part time

2. **Employee definition**:

   Full-Time Employee means:
   - ☒ A person who is regularly scheduled to work a minimum of 30 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.

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☒ Other: The 1st day of the month following or coinciding with 60 days of employement
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 to enroll 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 and/or dependents of domestic partners.

6. **Are unmarried grandchildren eligible for coverage**? ☒Yes (answer the question below) ☐ No
   Must the grandchild be dependent on the employee for federal income tax purposes at the time application is made? ☒ Yes ☐ No

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

8. **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
   **Automatically canceling dependents is not recommended for accounts with automated eligibility*

   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 and the Disabled Dependent provisions of this BPA. The Employer will notify BCBSTX *of any instance where the continuation of disabled dependent coverage is required.*

9. **Disabled dependent:** A disabled dependent means a dependent child who is medically certified as disabled and dependent upon the Employee or his/her spouse. A child is a disabled child when the child is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months, per Internal Revenue Code Section 22(e)(3).

   To administer medical certification of disabled dependents, you may select option (a) Standard Rules or (b) Custom Rules. BCBSTX will administer its standard process for administration of disabled dependent coverage if (a) below is selected by Employer, or at the Employer's direction memorialized below, BCBSTX will follow a customized process if Employer selects (b). If (b) is selected there are additional selections regarding age, proof of prior coverage, certification review, forms, and previous medical certification approvals.

(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 26. A disabled dependent is eligible to ***add*** coverage beyond the limiting age, provided the disability began before the child attained the age of 26, and proof of coverage as a disabled dependent is provided. Administration of certification review is administered by BCBSTX; a disabled dependent certification form must be submitted to BCBSTX.

(b) ☐ Disabled dependent Administration will follow **Custom Rules**. Please make the following sections:

Age: *Please select one option regarding age of when the disability began.*

☐ The disability must have begun before the child attained the age of 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 option regarding the administration of certification review.*
☐ Certification review is administered by BCBSTX; a disabled dependent certification form must be submitted to BCBSTX.
☐ Certification review is administered by the Employer; there are no disabled dependent certification form requirements.

If certification review is administered by BCBSTX, *please select one option regarding forms:*
☐ Utilize BCBSTX's disabled dependent certification forms.
☐ Utilize custom/other disabled dependent certification forms.

If Certification Review is administered by BCBSTX, *please select allowed or not allowed below:*
A disabled dependent approved certification from a prior insurance carrier is ☐ allowed ☐ not allowed.
A disabled dependent approved certification from a prior BCBS policy is ☐ allowed ☐ not allowed.

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 any applicable federal or state law. The Employer will notify BCBSTX *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 group coverage assistance under a state Medicaid or CHIP premium assistance program.

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 otherwise eligible to do so, during the Employer's annual 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: _____

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 otherwise 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.
Select one of the provisions below:
☒ Open Enrollment – Late applicants may only apply during Open Enrollment.
☐ Late Entrant – Late applicants may apply at any time – coverage effective date is determined by the receipt date and allowed rules governing off-cycle enrollments.

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*

Proprietary and Confidential Information of Claim Administrator
Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator.

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 probationary period _____
7. declining because of other group coverage (e.g., other commercial group coverage, Medicare, Medicaid, TRICARE/Champus) _____
8. declining coverage (not covered elsewhere) _____

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Lines of Business (Check all applicable services) ☐ NO CHANGES ☐ See *Additional Provisions*

Medical Plan Services:

☒ PPO: Plan Name: PPO Plan
Plan Name: PPO HSA Plan

☒ HMO: Plan Name: HMO Plan

☐ Prescription Drug Option: Select From List

☐ No Prescription Drug Option

☐ Blue High Performance Network℠ (BlueHPN℠)

☐ EPO: Plan Name: _____

☐ POS: Plan Name: _____

Additional Services:

☒ Wellbeing Management
☐ Wellness Incentives
☐ Health Advocacy Solutions
☐ Mercer Health Advantage
☐ Custom Care Management Unit
☐ Blue Directions℠ (Private Exchange) *(If selected, the Blue Directions Addendum must be attached and made a part of the parties' Administrative Services Agreement.)*
☐ In-Hospital Indemnity (IHI)
☒ Limited Fiduciary Services for Claims and Appeals
☒ Other Benefits Value Advisor
☐ Other Select Product
☐ Other
☐ Other

Consumer Driven Health Plan

☐ BlueEdge℠ HCA, *(if selected, complete separate HCA Benefit Program Application)*
☒ BlueEdge℠ HSA, (Preferred Vendor: Select Vendor)* If HealthEquity, Inc. is selected, BCBSTX to send HSA enrollment to HealthEquity, Inc☐ Yes ☐ No Non-Preferred Vendor: PlanSource
☐ FSA (Preferred Vendor: Select Vendor)* Non-Preferred Vendor:
☐ HRA (Preferred Vendor: Select Vendor)* Non-Preferred Vendor:

Traditional Coverage:

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

Prescription Drugs:

☒ *(If selected, the PBM Fee Schedule Addendum must be attached and is part of this BPA.)*
Pharmacy Network (Select one):
☒ Traditional Select Network
☐ Advantage Network
☐ Preferred Network
☐ Elite Network
☐ Network on PBM Fee Schedule Addendum
☐ Other (please specify):

Drug List: Balanced Drug List

Other (please specify):
PPO/HSA Preventive Drug List:
Please specify: Select Option
Other Rx programs:
Please specify: Select Program

Ancillary Services:

☐ Vision Insurance *(if selected, complete a separate application)*
☒ Stop Loss Coverage (*If selected, complete separate Application and Policy Schedule for Stop Loss Coverage*)
☐ Life, Disability, Specified Disease, Accident or Hospital Indemnity Insurance (*If selected, complete a separate application for those coverages*)
☐ COBRA Administrative Services (*If selected, complete separate HCSC COBRA Administrative Services Addendum)*
☐ Dental Plan Services
Plan Name: _____ Select From List

*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.

Mercer Health Advantage is offered by Mercer, an independent company, and is administered by Blue Cross and Blue Shield of Texas.
Custom Care Management Unit is offered by Willis Towers Watson, an independent company, and is administered by Blue Cross and Blue Shield of Texas.
Medical and Dental benefits and services are administered by Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.
Life, Disability, Specified Disease, Accident, Hospital Indemnity and Vision Insurance is underwritten by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Blue Cross and Blue Shield of Texas is the trade name of Dearborn Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

FEE SCHEDULE

Employer shall pay amounts Claim Administrator bills Employer for benefit claims Claim Administrator processes on Employer's behalf as well as administrative fees as set forth in this 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 (cannot be selected if Check is selected as payment method above)

☒ Monthly

Claim Settlement Period: ☒ Weekly ☐ Monthly

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

Fee Schedule Period: To begin on Effective Date of Coverage and continue for 12 months. If other than 12 months, please specify: months.

Administrative Per Employee per Month (PEPM) Charges ☐ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

	2024	2025	2026	2027
Administrative Fee	$37.43	$38.42	$40.26	$42.16
Dental	$_____	$_____	$_____	$_____
Claims Fiduciary	$1.00	$1.00	$1.00	$1.00
Advanced Payment Review	25% $	25% $	25% $	25% $
*Medical Drug Rebate Credit	$(2.50)	$(2.50)	$(2.50)	$(2.50)
*Rebate Credit for the Prescription Drug Program	$(66.30)	$(72.93)	$(72.93)	$(72.93)
Telehealth (Virtual Visits)	$0.52	$0.52	$0.52	$0.52
Wellbeing Management	$4.95	$4.95	$4.95	$4.95
Health Advocacy Solutions	$_____	$_____	$_____	$_____
Commissions: _____	$_____	$_____	$_____	$_____
Commissions: _____	$_____	$_____	$_____	$_____
Commissions: _____	$_____	$_____	$_____	$_____
Other: Benefits Value Advisor List Service: _____	$2.50	$2.50	$2.50	$2.50
Other: Other Services List Service: _____	$_____	$_____	$_____	$_____
Other: Other services List Service: EAP	$1.90	$_____	$_____	$_____
Miscellaneous: _____	$_____	$_____	$_____	$_____
Miscellaneous: _____	$_____	$_____	$_____	$_____
Total	$(20.50)	$TBD	$TBD	$TBD

Proprietary and Confidential Information of Claim Administrator
Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator.

*The Rebate Credit is a per Covered Employee per month credit applied to the monthly billing statement. The Employer and Claim Administrator have agreed to the Rebate Credit and Employer agrees that it and its group health plan have no right to, or legal interest in, any portion of the rebates, either under the pharmacy benefit or the medical benefit, actually provided by the Pharmacy Benefit Manager ("PBM") or a pharmaceutical manufacturer to Claim Administrator and consents to Claim Administrator's retention of all such rebates. The Rebate Credit will be provided from Claim Administrator's own assets and may or may not equal the entire amount of rebates actually provided to Claim Administrator by the PBM or expected to be provided. Rebate Credits shall not continue after termination of the Prescription Drug Program. Employer agrees that any Rebate Credit provision in the governing Administrative Services Agreement to the contrary is hereby superseded.

Administrative Line Item Charges ☐ **SEE ADDITIONAL PROVISIONS**	**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: _____	$_____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	_____%
	Total:	$_____

Other Service and/or Program Fee(s) ☒ **NO CHANGES** ☐ **SEE ADDITIONAL PROVISIONS**

NSA Fees

In connection with the claims, items, and services that are subject to the No Surprises Act ("NSA") and disputed by a Provider, Employer agrees to pay Claim Administrator the following fees:

- Fifty dollars ($50) for each claim that is the subject of informal negotiation with a Provider (this fee will be charged in the event the Provider, in its sole discretion, determines that it will not accept the initial payment amount); and
- An additional seventy-five dollars ($75) per claim for each independent dispute resolution process ("IDR") where Claim Administrator represents Plan (this fee will be charged in the event the Provider, in its sole discretion, determines that it will initiate IDR after the informal negotiation period); and

All costs imposed by the IDR entity or any state, federal or local government entity in connection with an IDR.

Not applicable to Grandfathered Plans

External Review Coordination: ☒ Yes ☐ No

If yes, coordination fee: $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. Employer elects for external reviews to be performed under the Affordable Care Act external review process.

If no, provide name and address of administrator(s) of external review coordination and indicate if administrating medical claims and/or pharmacy claims:

Administrator: Medical claims: ☐ Pharmacy claims: ☐ Name: Mailing Address:
Administrator: Medical claims: ☐ Pharmacy claims: ☐ Name: Mailing Address:

Proprietary and Confidential Information of Claim Administrator
Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator.

Advanced Payment Review (APR): ☒ Yes ☐ No

APR is a suite of payment integrity offerings. Refer to the Matrix. If Employer elects APR, indicate APR Savings Program or PEPM below:

☒ APR Savings Program

☐ PEPM

For APR capabilities other than Reimbursement Services: If Employer elects APR Savings Program, Claim Administrator will invoice the percentage indicated in the Fee Schedule of any savings amounts identified by Claim Administrator or third-party.

Reimbursement Services: ☒ Yes ☐ No If yes, Claim Administrator will retain twenty-five percent (25%) of any recovered amounts made on third-party liability claims other than recovery amounts received as a result of or associated with any Workers' Compensation Law.

FlexAccess™: ☐ Yes ☒ No

As part of its plan design, Employer has directed Claim Administrator to administer claims, copay and coinsurance requirements for Covered Persons enrolled in the FlexAccess program, including (i) adjusting Covered Persons' copayment amounts to the amount of the manufacturer copay assistance, (ii) applying such manufacturer assistance to reduce Covered Persons' out of pocket costs, and (3) not applying the manufacturer assistance to Covered Persons' deductibles and out of pocket maximum accumulators. Employer agrees that FlexAccess is a plan design decision of Employer and is consistent with Employer's plan design and supported by plan documents. Employer further agrees it is solely responsible for, and will hold Claim Administrator harmless for, the legal and regulatory compliance of the Plan and its plan design.

Claim Administrator will assess a program fee equal to 20% of the total shared savings. Total shared savings is calculated as follows:

The difference between Employer responsibility without the FlexAccess Program and Employer responsibility with the FlexAccess Program. The Employer responsibility with the FlexAccess Program is cost of the drug minus: (1) the manufacturer copay assistance dollars that are allocated to the cost of the drug and (2) the member's cost share for the member enrolled in the program. The Employer responsibility without the FlexAccess Program is the cost of the drug minus the member cost share if the member was not enrolled in the program.

FLEXACCESS™ QUALIFIED HDHP: ☐ Yes ☒ No

Claim Administrator will assess a fee equal to 20% of program savings for administrative fees. Program savings (shared savings) will be calculated based on the manufacturer copay assistance dollars that are allocated to the cost of the drug minus the member's estimated cost share (copay or coinsurance) that would have been paid if they were not enrolled in the program.

The difference between Employer Responsibility for claims utilizing FlexAccess Qualified HDHP and not utilizing FlexAccess Qualified HDHP includes as follows:

WITH FLEXACCESS QUALIFIED HDHP: Cost of drug – amount manufacturer copay assistance used – Member out-of-pocket cost (if any) up to Deductible... Copay assistance reversed from deductible. Plan pays no portion.

WITHOUT FLEXACCESS QUALIFIED HDHP: Cost of drug – member out-of-pocket cost - Non-FlexAccess Qualified HDHP coupon... Copay assistance applied to Deductible. Plan may pay portion of claim after deductible met

Third-Party Law Firms Provisions (other than Reimbursement Services): Employer will pay no more than 35% of any recovered amount made by Claim Administrator's third-party law firm or up to 35% of any recovered amount will be deducted from the amount distributed according to established allocation processes.

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 between the Claim Administrator and the Employer.

Virtual Visits Program: ☒ Yes ☐ No If yes, Covered Persons would be able to obtain certain Covered Services remotely via interactive video and/or interactive audio/video (where available) capability from Virtual Visits powered by MDLIVE.

MDLIVE® is a separate company that operates and administers Virtual Visits for persons with coverage through Blue Cross and Blue Shield of Texas. MDLIVE is solely responsible for its operations and for those of its contracted providers. MDLIVE® and the MDLIVE logo are registered trademarks of MDLIVE, Inc., and may not be used without permission.

Termination Administrative Charges				
As applies to the Run-Off Period indicated in the Payment Specifications section above: 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. In the event of a partial termination, the Termination Administrative Charge shall be the sum of the amount obtained by multiplying three (3) times the total number of terminated Covered Employees by the appropriate factors shown below.				
Service	**2024**			
Medical Run-off Administration Charge	**$10.19**	$____	$____	$____
Dental Run-off Administration Charge	$____	$____	$____	$____
Miscellaneous	$____	$____	$____	$____
Miscellaneous	$____	$____	$____	$____
Total:	**$10.19**	$____	$____	$____

Other Provisions ☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

1. **Summary of Benefits & Coverage**:
   a. Will Claim Administrator create Summary of Benefits and Coverage (SBC)?
      ☒ Yes. (Please answer question b. The SBC Addendum is attached.)
      ☐ No. (If No, then skip question b and refer to the Administrative Services Agreement for further information.)
   b. Will Claim Administrator distribute the (SBC) to Covered Persons?
      ☐ No. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Administrative Services Agreement) and provide SBC to Employer in electronic format. Employer will then distribute SBC to Covered Persons (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 Administrative Services Agreement) and distribute SBC to Covered Persons via regular hardcopy mail or electronically. Distribution Fee for hardcopy mail is one dollar fifty cents ($1.50) per package.

2. **Massachusetts Health Care Reform Act**:
   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? ☐ Yes ☐ No

   If no: The Employer acknowledges (1) it will provide written statements and electronic reporting to the Massachusetts Department of Revenue if required by the Massachusetts Health Care Reform Act or (2) that it does not believe it is subject to the notification and reporting requirements of the Massachusetts Health Care Reform Act.

3. **Alternative Care Management Program** (applicable to the purchased medical management program):
   ☐ Yes ☒ No
   The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons for Utilization Management, Case Management, including but not limited to Behavioral Health, and other health care management programs.

4. **Prior Authorization** (applicable to the purchased medical management program): Employer acknowledges and agrees to utilize Claim Administrator's standard list of services and supplies for which Prior Authorization (also called pre-notification or preauthorization) is required.

5. **Essential Health Benefits ("EHB") Election**:
   Employer elects EHBs based on the following:
   1. ☒ EHBs based on a Claim Administrator state benchmark:

☐ Illinois ☐ Montana ☐ New Mexico ☐ Oklahoma ☒ Texas

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 BPA is binding on both parties and is incorporated into and made a part of the Administrative Services Agreement between the parties with both such documents to be referred to collectively as the "Administrative Services Agreement" unless specified otherwise.

8. **Independent Dispute Resolution Process**:
   Employer authorizes and directs Claim Administrator to offer an amount not to exceed the greater of the Qualifying Payment Amount (QPA) or the amount allowed on the initial notice of payment or denial of a claim on behalf of the Employer during negotiations under the federal IDR process.

Additional Provisions: BCBSTX will prodivde an annual transition credit of $30,000 beginning 10/01/2023 and continuing for 5 years at each renewal for a total of $150,000 in funding, to be used to cover costs and and expenses associated with transitioning medical, prescription, stop loss, ancillary health or other coverage to BCBSTX and/or costs and expenses associated with transitioning to a new product design with BCBSTX. If employer cancels before expiration of the policy period, Employer will be responsible for refunding to BCBSTX the full amount of the transition credit.

The medical administrative fee shown in this BPA reflects a volume-based discount in an amount equal to $1.00 PEPM of the medical administrative fee for the twelve-month period beginning on the contract effective date for the purchase of a dental coverage from BCBSTX

Proprietary and Confidential Information of Claim Administrator
Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator.

Signature

Amy Westendorf

Sales Representative

District Phone & FAX Numbers

Producer Representative

Producer Firm

Producer Address

Producer Phone & FAX Numbers

Producer Email Address

Tax I.D. No.

Signature of Authorized Purchaser

Randy Gillespie

Print Name

Personnel Director

Title

10/15/2024

Date

Proprietary and Confidential Information of Claim Administrator
Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator.

PROXY

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members is scheduled to be held each year in the HCSC corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice provided to the member not less than thirty (30) nor more than sixty (60) days prior to such meetings. This proxy shall remain in effect until either 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 its directors, officers, employees or agents consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

☐ Intentionally left blank by the Employer

Group No.: _____ By: Randy Gillespie
Print Signer's Name Here

➡ _____ Personnel Director
Signature and Title

Group Name: _____

Address: 2 N. Main Street

City: Cleburne State: Texas ZIP: 76033

Dated this 15th day of October 2024
Month Year

BlueCross BlueShield of Texas

APPLICATION AND POLICY SCHEDULE FOR STOP LOSS COVERAGE

Employer Group Name:	County of Johnson		
Employer Group Address:	2 N Main St Room 215		
City:	Cleburne	**State of Situs:** TX	**Zip Code:** 76033
Account Number:	369192		
Employer Group Number(s):	369192, 369193, 369194		
Original Effective Date of Stop Loss Policy	10/01/2023		
Current Policy Effective Date:	10/01/2024		

Current Policy Period The specifications set forth in this Application are for the Policy Period commencing on 10/01/2024 and ending on 12/31/2024.

The specifications below shall become effective on the first date of the Policy Period specified above and shall continue in full force and effect until the earliest of the following dates: (1) The last day of the Policy Period; (2) The date the Policy terminates; or (3) The date this Application is superseded in whole or in part by a later executed Application.

A. Covered Employees:

Number of Single Coverage Units:	596
Number of Family Coverage Units:	166

B. Individual Stop Loss Coverage:

1. New Coverage ☐ Renewal of Existing Coverage ☒

2. Stop Loss coverage during the Current Policy Period

   ☒ **12/12**

   Coverage for Claims incurred from 10/01/2024 to 12/31/2024 and Claims paid from 10/01/2024 to 12/31/2024.

   If 24/12, 18/12, 15/12, or 12/12 are selected, Employer Group understands that run-out coverage is not included, and Employer Group represents that it intends to purchase run-in coverage from its next carrier.

   For new coverage only, if a run-in contract as explained in the Stop Loss Policy (24/12, 18/12, or 15/12 coverage period) is purchased, claims paid by the Employer Group's prior claim administrator will be settled at the time of the annual stop loss settlement and must be reported by the Employer Group to the Company (Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) by the end of the Employer Group's Current Policy Period or stop loss coverage for these run-in claims will be forfeited.

   ☐ (Paid Renewal Only) Claim Administrators Claims: Claims incurred on or after the Original Effective Date of Policy and paid during the Policy Period.

3. Covered Expenses includes:

   ☒ Medical Claims:
   ☒ Prescription Drug Claims with: Prime (Preferred PBM) _____

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company
an Independent Licensee of the Blue Cross and Blue Shield Association

☐ For **Hospital Employer Groups only:** Excludes _____% of Home Hospital Medical claims
☐ Other (for example Dental/Vision): _____.

4. Individual Stop Loss Provisions

a. Individual Stop Loss Deductible: $125,000
Applies per Covered Person for the Employer Group's Current Policy Period.

b. Aggregating Specific Deductible (if applicable): $_____

c. Lasered Individuals with Individual Stop Loss Deductible (if applicable):
Individual identifier, alternate Individual Stop Loss Deductible:
$_____

d. Lasered Individuals excluded from Stop Loss Coverage (if applicable):
Individual identifier:

_____

e. If a run-in contract (24/12, 18/12, or 15/12 coverage period) is purchased, per Item 2. above, run-in claims are covered with a maximum liability of: $_____ per Covered Person.

5. Terminal Liability Option (TLO) (does not apply to Employer Groups with 12/15, 12/18, or 12/24 contracts):
☒ Yes ☐ No

The following applies if the answer to item above is "Yes" (Terminal Liability Option):

Must be elected at Policy inception or renewal. Premium cost is calculated by taking the average enrollment for the last two months of the Current Policy Period multiplied by three times pre-termination Individual Stop Loss rate(s). Premium is due at the time of termination, payable by lump sum within 10 days of receipt of bill. Claims will accumulate and be combined under one Individual Stop Loss Deductible specified in item B.4.a above for the Current Policy Period and Terminal Period. The Settlement for the Final Accounting Period will be described in the section of the Policy entitled SETTLEMENTS.

6. Individual Stop Loss Premium
Monthly Individual Stop Loss Premium shall be equal to the amounts obtained by multiplying the number of Covered Employees for a particular Month by:

$181.65 Composite; or
$_____for each Single Coverage Unit
$_____ for each Family Coverage Unit

C. **Aggregate Stop Loss Coverage**: Yes ☒ No ☐
If yes, complete Items 1. through 5. Below:

1. New Coverage ☐ Renewal of Existing Coverage ☒

2. Stop Loss Coverage during the current Policy Period

☒ **12/12**

Coverage for Claims incurred from 10/01/2024 to 12/31/2024 and Claims paid from 10/01/2024 to 12/31/2024.

If 24/12, 18/12, 15/12, or 12/12 are selected, Employer Group understands that run-out coverage is not included, and Employer Group represents that it intends to purchase run-in coverage from its next carrier.

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For new coverage only, if a run-in contract as explained in the policy (24/12, 18/12, or 15/12 coverage period) is purchased, claims paid by the Employer Group's prior claim administrator will be settled at the time of the annual stop loss settlement and must be reported by the Employer Group to the Company (Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) by the end of the Employer Group's Current Policy Period or stop loss coverage for these run-in claims will be forfeited.

☐ (Paid Renewal Only) Claim Administrators Claims: Claims incurred on or after the Original Effective Date of Policy and paid during the Policy Period.

3. Covered Expenses:

☒ Medical Claims
☐ Claim Administrator's Provider Access Fees
☒ Prescription Drug Claims with: Prime (Preferred PBM) _____
☐ For **Hospital Employer Groups only:** Excludes _____% of Home Hospital Medical claims
☐ Other (for example Dental/Vision): _____

4. Aggregate Claim Liability

a. Attachment Factor 125% of the Average Claim Value
b. Aggregate Claim Factors:

Group Number:	ALL			
Composite; or	$1,443.20	$_____	$_____	$_____
For each Single Coverage Unit	$_____	$_____	$_____	$_____
For each Family Coverage Unit	$_____	$_____	$_____	$_____

c. Minimum Aggregate Point of Attachment: $2,969,240

5. Terminal Liability Option (TLO) (does not apply to Employer Groups with 12/15, 12/18, or 12/24 contracts):
☒ Yes ☐ No

The following applies if the answer to item above is "Yes" (Terminal Liability Option):

Must be elected at Policy inception or renewal. Premium cost is calculated by taking the average enrollment for the last two months multiplied by three times pre-termination Aggregate Stop Loss rate(s). Premium is due at the time of termination, payable by lump sum within 10 days of receipt of bill.

The Final Settlement Point of Attachment shall equal the sum of the Employer's Aggregate Claim Liability amount for the Policy Period plus 15% of the Aggregate Claim Factor multiplied by 12, and then multiplied by the average enrollment for the last two (2) months of the Current Policy Period immediately preceding termination. Furthermore, for the Final Settlement Period, the Minimum Aggregate Point of Attachment shall be the Minimum Aggregate Point of Attachment in item C.4.c. above increased by 15%. The Settlement for the Final Accounting Period will be described in the section of the Policy entitled SETTLEMENTS.

6. Aggregate Stop Loss Premium:
☒ Monthly Premium
Monthly Aggregate Stop Loss Premium shall be equal to the amounts obtained by multiplying the number of Covered Employees for a particular Month by:
$4.04 Composite; or
$_____ for each Single Coverage Unit
$_____ for each Family Coverage Unit

☐ Annual Premium (Due on the first day of the Current Policy Period): $_____

D. Additional Provisions (if elected):

1. Retirees Covered (select if included):
   Pre-65: ☐ or Post-65: ☐

2. Home Hospital Employer Groups Only: Home Hospital Provider Number(s) subject to exclusion percentage per Item B.3. & C.3.: _____

3. Monthly Aggregate Accommodation: ☐ Yes ☐ No

4. Additional information: _____

Fraud Notice: Any person who knowingly, with intent to injure, defraud or deceive any insurance company submits an application containing any false, incomplete, or misleading information, may be subject to prosecution and may be found guilty of a felony under state law and subject to punishment, including fines and/or imprisonment. Submission of false information in connection with this application may also constitute a crime under federal laws. All appropriate legal remedies will be pursued in the event of insurance fraud, including prosecution under Federal Mail or Wire Fraud statutes, and/ or the Federal Racketeer Influenced and Corrupt Organizations Act. Any false statements made herein may be reported to state and federal tax and regulatory authorities as is appropriate.

The undersigned person represents that he/she is authorized and responsible for purchasing Stop Loss Coverage on behalf of the Employer Group. It is understood that the actual terms and conditions of coverage are those contained in this Application and the Stop Loss Coverage Policy into which this Application shall be incorporated at the time of acceptance by Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC"). Upon acceptance, HCSC shall issue a Stop Loss Coverage Policy to the Employer Group. Upon acceptance of this Application and issuance of the Stop Loss Coverage Policy, the Employer Group shall be referred to as the "Policyholder".

Amy Westendorf
Sales Representative

Signature of Authorized Purchaser

Personnel Director
Title of Authorized Purchaser

10/15/2024
Date

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company
an Independent Licensee of the Blue Cross and Blue Shield Association

PBM Fee Schedule Addendum to the Benefit Program Application

County of Johnson	
Term: 10/01/2024-01/01/2025	Employees: 807
Guaranteed Traditional Aggregate Pricing Arrangement C[1]*	
Traditional Select Network and Balanced Drug List	
RETAIL	
Brand	**Generic**
AWP minus	**AWP minus**
19.40%	83.40%
DISPENSING FEE	
Brand	**Generic**
$0.75	$0.75
MAIL	
Brand	**Generic**
AWP minus	**AWP minus**
23.65%	85.85%
DISPENSING FEE:	$0.00
EXTENDED SUPPLY NETWORK ("ESN") (If Applicable)	
Brand	**Generic**
AWP minus	**AWP minus**
22.65%	85.85%
DISPENSING FEE:	$0.00
Aggregate Specialty Discount	
Pricing based on Employer's use of the Prime Specialty network	AWP minus: 21.15%
DISPENSING FEE:	$0.00

Rebate Credits to Employer:	
PEPM Rebate Credits to Employer:	$66.30

Employer Administration Fees:	
PBM Administration Fees PEPM:	$0.00

Additional Provisions:

[1] Employer will be billed for retail brand and retail generic prescriptions, mail brand and mail generic prescriptions, ESN brand and ESN generic, and Specialty pharmacy claims (excluding compound prescriptions) based on the lesser of (a) U&C or (b) PBM's adjudication rate schedule(s) that is/are intended to achieve, on an aggregate calendar-year basis, the AWP discounts and Dispensing Fees shown above for all of Claim Administrator's group customers that have purchased the above specific pricing arrangement ("Groups with the Pricing Arrangement") and use the above Network (the "Employer's Contract Rates").

For purposes of setting Employer's Contract Rates and calculating whether the AWP discounts and Dispensing Fees have been achieved:

a. Brand drugs are defined as all drugs that have a Medi-Span multisource code field equal to "M", "N", or "O".

b. Generic drugs are defined as all drugs available in sufficient supply that have a Medi-Span multisource code field equal to "Y".

Employer acknowledges and agrees that Employer's Contract Rates may vary based on market influences and as necessary to achieve the AWP discounts and Dispensing Fees shown above, on an aggregate calendar year basis, for Groups with the Pricing Arrangement that use the above Network. However, such variation for Brand products in each of the Retail, Mail, and ESN categories (on an aggregate annual basis) may only vary by +/-3% from the applicable AWP discount shown above.

Employer will be billed the above Dispensing Fee (such Fee may be included in the amount billed to Employer) unless the Employer is billed based on the U&C price. If the Employer is billed based on the U&C price, then the Dispensing Fee is included in such U&C price.

Employer will be billed for Compound Drug claims based on the applicable discounted rate in the Network Contract.

Employer will be billed for Foreign Claims based on an amount equal to the amount billed by the pharmacy.

Employer will be billed for out-of-network claims based on the pricing set forth in the Administrative Services Agreement and/or PBM Exhibit, as applicable.

If the AWP discounts and Dispensing Fees shown above are not achieved for a particular calendar year, for Groups with the Pricing Arrangement that use the above Network, then Employer will be credited, no later than 180 days after the end of each calendar year during the Term, an amount calculated as follows:

- First, the total aggregate shortfall dollar amount for the calendar year for Groups with the Pricing Arrangement that use the above Network will be calculated by comparing the actual performance of each of the above categories (Retail, Mail, ESN, and Specialty) with the corresponding AWP discounts and Dispensing Fees shown above for each category. The amount of any performance in any category that exceeds the above AWP discounts and Dispensing Fees will be used to offset any and all shortfall(s) in any or all categories. The above aggregate shortfall, if any, is then divided by total claims for Groups with the Pricing Arrangement that use the above Network, and did not terminate their Addendum prior to their anniversary date, for the calendar year ("Per Claim Amount"). Then the Per Claim Amount will be multiplied by Employer's total claims for that calendar year to calculate the reconciliation credit. However, if Employer terminates this Addendum prior to its anniversary date and the above Guaranteed Traditional Aggregate Pricing Arrangement is not achieved, then Employer will not be eligible to receive such credit.

- For purposes of determining if a shortfall exists, claims billed to Employer based on the U&C price will be considered to have $0.00 Dispensing Fees.

- Compound Drug claims, Foreign Claims, reversed claims, long term care (LTC) home infusion pharmacy, veterans affairs pharmacy, Indian/tribal/urban pharmcy, 340B, Medicare/Medicaid, member submitted, coordination of benefits (COB), subrogation, paper, invalid, usual and customary (U&C) claims and out-of-network claims are excluded from the calculation of whether the AWP discounts and Dispensing Fees shown.

- Non-specialty discount and dispensing fees also exclude specialty (as defined by the BCBS specialty drug pricing file.

- If the AWP discounts and Dispensing Fees shown above are exceeded for Groups with the Pricing Arrangement that use the above Network, then Employer will not receive any credit, and there will not be a year-end settlement.

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- Under the Guaranteed Traditional Aggregate Pricing Arrangement any particular group customer's experience relative to the pricing guarantees will not determine its eligibility for a credit. Group customer's eligibility for a credit is determined based on the aggregate experience of all group customers that have purchased the Pricing Arrangement and use the above Network. As such, an individual group customer may have experience that does not meet, or exceeds, the AWP discounts and Dispensing Fees shown above. In addition, when there is a reconciliation credit, it is allocated in a manner described above and not based on any particular group's experience (other than number of claims).

- MedsYourWay program claims will be included in calculation of the discount and Dispensing Fee pricing guarantees. MedsYourWay is the embedded drug discount card comparison program utilized where available and applicable to Employer, Network Pharmacy, and the Covered Drug.

PBM uses Medi-Span as the pricing source to establish AWP, for purposes of calculating whether the above AWP discounts have been achieved.

Members' cost share is the applicable copayment, deductible, and/or coinsurance, which coinsurance is calculated based on the Employer's Contract Rate or the applicable out-of-network pricing. Zero balance logic is not employed.

AWP discounts are based on the actual NDC-11 dispensed.

AWP discounts do not include savings from drug utilization review or other clinical or medical management programs.

The above Guaranteed Traditional Aggregate Pricing Arrangement, Rebate Credits and Administrative Fees may be subject to change if the Employer's claims include 340B pricing.

In addition to the rights of the parties under the PBM Exhibit, if changes occur within the pharmacy benefit management marketplace which lead to a significant deviation from the current economic environment, both parties agree to engage in good faith negotiations to amend this Addendum to make impact on both parties commercially reasonably economically neutral. If the parties cannot agree on the terms of the amendment, either party shall be allowed to (a) proceed to dispute resolution, as set forth in the Administrative Services Agreement or (b) terminate this Addendum with 90 days' prior written notice to the other party. Failure to reach agreement on the amendment shall not be a breach of contract.

The above Guaranteed Traditional Aggregate Pricing Arrangement, Rebate Credits and Administrative Fees are based on the Network and Drug List shown above.

Unless otherwise specified in this Addendum, capitalized terms used in this Addendum shall have the meanings set forth in the Administrative Services Agreement or the PBM Exhibit, as applicable.

* Employer Payments to Claim Administrator for Covered Services provided by Network Participants are calculated based on the pricing terms set forth in this Addendum which shall remain in effect for the term of this Addendum to the extent described in the Administrative Services Agreement. Such pricing may or may not equal the amounts actually paid to the Network Participants or received from drug manufacturers (e.g., rebates), or the amounts paid or received between Claim Administrator and the PBM. As a result, the PBM or Claim Administrator may realize positive margin on prescriptions filled at retail, mail order, ESN or specialty pharmacies or prescription drug rebates. Employer acknowledges that it has negotiated for the specific traditional pricing terms set forth in this Addendum, and that it and its group health plan have no right to, or legal interest in, any portion of any positive margin retained by Claim Administrator or PBM and consents to Claim Administrator's and PBM's retention of all such amounts.

Signature of Authorized Purchaser

Randy Gillespie

Print Name

Personnel Director

Title

10/15/2024

Date

Proprietary and Confidential Information
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BlueCross BlueShield of Texas

1001 E. Lookout Drive
Richardson, Texas 75082

BENEFIT PROGRAM APPLICATION ("BPA")

Blue Cross and Blue Shield of Texas (herein called "BCBSTX")

LARGE GROUP PLANS

Account Status: ☐ New ☒ Existing with Changes

Off Cycle Change: ☐ Yes ☒ No ☐ Former BCBSTX ASO converting to fully insured

Account Number (6-digits): 369192 Group Number(s): 370072, 396140

Policy Effective Date (month/day/year): 01/01/2025 Policy Anniversary Date (month/day/year): 01/01/2026

Legal Account Name: County of Johnson
(Specify the Employer or the employee trust applying for coverage. An employee benefit plan may not be named)

☒ **NO CHANGES** **GROUP INFORMATION**

Employer Identification Number ("EIN"): 756001030

Standard Industry Code ("SIC"): 9111 Nature of Business: Non-Federal Govermental Agency / County

Primary (Mailing) Address: 2 N. Main St. Room 215

City: Cleburne State: TX Zip: 76033

Administrative Contact: Title:
Randy Gillespie Personnel Director
Phone: 817-556-6194 Fax: 817-556-6899 Email: randyg@johnsoncountytx.org

Blue Access for Employers℠ ("BAE℠") Contact: Title:
Darla Medford HR Generalist/ Benefit Coordinator
The BAE Contact is an Employee of the account who is authorized by the Employer to access and maintain the account in BAE.
Phone: 817-556-6349 Fax: 817-556-6899 Email: dmedford@johnsoncountytx.org

Administrative Contact (if different from Primary): Title:
Darla Medford HR Generalist / Benefits Coordinator
Phone: 817-556-6349 Fax: 817-556-6899 Email: dmedford@johnsoncountytx.org

Physical Address (if different from Primary - required): 2 N. Main St. Room 215
City: Cleburne State: TX Zip: 76033

Contact: Darla Medford

Billing Address (if different from Primary): 2 N. main St. Room 215

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Medical and Dental benefits are offered by Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

Life, Disability, Specified Disease, Accident, Hospital Indemnity and Vision insurance is underwritten by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Dearborn Life Insurance Company is an independent Blue Cross and Blue Shield licensee. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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City: Cleburne State: TX Zip: 76033

Billing Contact: Laura Baxter Title: Personnel Assistant
Phone: 817-556-6162 Fax: 817-556-6899 Email: laurab@johnsoncountytx.com

Do you cover any wholly owned subsidiary or affiliated companies? ☒ Yes ☐ No If yes, please list below:
Subsidiary Companies to be covered (if more than one, list within the Additional Provisions):
Central Appraisal District

Subsidiary Address: 109 N Main St

City: Cleburne State: TX Zip: 76033

Contact: Darla Medford Title: HR Generalist / Benefits Coordinator

Phone: 817-556-6349 Fax: 817-556-6899 Email: dmedford@johnsoncountytx.org

Affiliated Companies to be covered (if more than one, list within the Additional Provisions):

_____

Location(s): _____

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 your ERISA Plan Year* a period of 12 months beginning on the Anniversary Date specified above? ☐Yes ☐No

If no, please specify your ERISA Plan Year (month/day/year): Beginning Date ____/____/____ End Date ____/____/____

ERISA Plan Administrator*: _____

Plan Administrator's Address: _____

If you maintain that ERISA is not applicable to your 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
☐ Other; please specify: _____

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

If no, please specify your ERISA Plan Year (month/day/year): Beginning Date ____/____/____ End Date ____/____/____

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

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☒ NO CHANGES **PRODUCER OF RECORD INFORMATION**

1. *Producer/Agency** name to whom commissions are to be paid: Holmes Murphy & Associates LLC
Producer Number of ☐ Producer or ☒ Agency: 000013905
Street Address: 12712 Park Central Drive, Suite 100
City: Dallas Zip: 75251
Phone: 800-882-5949 Fax: _____
Email: jrickman@holmesmurphy.com
Is Producer/Agency appointed with BCBSTX? ☒ Yes ☐ No Affiliated with General Agent? ☐ Yes ☒ No
Commissions:
☒ PCPM $0 Does a Monthly Cap Apply ☐ Yes ☐ No $ (If cap is annual, divide by twelve)
☐ Flat $ Does a Monthly Cap Apply ☐ Yes ☐ No $ (If cap is annual, divide by twelve)
ADDITIONAL COMMISSIONS:

2. *Producer/Agency** name to whom commissions are to be paid: _____
Producer Number of ☐ Producer or ☐ Agency: _____
Street Address: _____
City: _____ Zip: _____
Phone: _____ Fax: _____
Email: _____
Is Producer/Agency appointed with BCBSTX? ☐Yes ☐No Affiliated with General Agent? ☐ Yes ☐ No
Commissions:
☐ PCPM $ Does a Monthly Cap Apply ☐ Yes ☐ No $ (If cap is annual, divide by twelve)
☐ Flat $ Does a Monthly Cap Apply ☐ Yes ☐ No $ (If cap is annual, divide by twelve)
ADDITIONAL COMMISSIONS:
If commission split, designate percentage for each producer/agency **Note**: total commissions paid must equal one hundred percent (100%)
Producer/Agency 1: _____% Producer/Agency 2: _____%

3. Writing Producer's Name (please print):
Producer Number: _____ Phone: _____ Email: _____
Writing Producer's Signature: _____ Date: _____

*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 BCBSTX.

☒ NO CHANGES **SCHEDULE OF ELIGIBILITY**

1. **Standard Eligibility Provisions:** Eligible Employee/Subscriber means an Employee who works on a full-time basis, who usually works at least thirty (30) hours a week, and who otherwise meets the Participation Criteria established by an Employer. The term includes a sole proprietor, a partner, and an independent contractor, if the individual is included as an Employee under a Health Benefit Plan of a large Employer regardless of the number of hours the sole proprietor, partner, or independent contractor works weekly, but only if the plan includes at least two (2) other Eligible Employees who work on a full-time basis and who usually work at least thirty (30) hours a week. Participation Criteria means any criteria or rules established by a large Employer to determine the Employees who are eligible for enrollment or continued enrollment under the terms of a Health Benefit Plan. The Participation Criteria may not be based on Health Status Related Factors.

(HMO only) the Eligible Subscriber must reside, live, or work in the Service Area.

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2. **Other Eligibility Provisions (check all that apply):**

☒ Retiree of the Employer.
☐ Part-time Employee of the Employer.
☐ Other: _____

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

Domestic Partners covered: ☐ Yes ☒ No
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. An Employer may only elect or change Domestic Partner Coverage on the Policy Effective Date or Policy Anniversary Date.

Continuation coverage for Domestic Partners: If Employer elects coverage for Domestic Partners, a Domestic Partner is eligible for continuation coverage under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) if an eligible Employee elects COBRA coverage. Employer may also elect whether to provide continuation 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 an Employee's election of COBRA.
☐ No, Employer does not elect to offer continuation coverage to Domestic Partners on an independent basis from an Employee's election of COBRA (Domestic Partners are not independently eligible for continuation coverage)
☐ Other: _____

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

If a person is added to the Policy and it is later determined that the Policyholder reported a coverage date earlier than what would apply to the Employee or Dependent, 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.

What is the effective date for a newly eligible person who becomes effective after the Employer's initial enrollment? (No effective date may exceed ninety-one (91) calendar days from the date that an individual becomes eligible for coverage, unless permitted by applicable law.)

☐ 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 1st day (standard is first (1st) or fifteenth (15th)) of the month following sixty (60) days of employment.
☐ The _____ day (standard is first (1st) or fifteenth (15th)) of the month following select one month(s) of employment.

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 (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

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☐ 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: Part- time employee moving to full-time, benefits will start the 1st of the following month as will as long as they have completed their 60 days of employement

(HMO only) What is the effective date of coverage for a Newly Eligible Employee who becomes effective after the Employer's initial enrollment date? (No effective date may exceed ninety-one (91) calendar days from the date that an individual becomes eligible for coverage, unless permitted by applicable law.)

☐ The first (1st) day of the month following the date of employment (date of hire).
☒ The first (1st) day of the month following sixty (60) days of employment.
☐ The first (1st) day of the month following select one month(s) of employment.

4. **Are there multiple new hire Waiting Periods?** ☐ Yes ☒ No
If yes, attach eligibility and contribution details for each section.

Is the Waiting Period requirement to be waived on initial group enrollment?
Health ☐ Yes ☐ No ☐ N/A Dental ☒ Yes ☐ No ☐ N/A

5. **Annual Open Enrollment:** For Health and Dental Plans only, an Eligible Person, 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. Such person's individual coverage date, family coverage date and/or Dependent's coverage date will be the Policy Anniversary Date following the Open Enrollment Period, provided the application is dated and signed prior to that date.

The Open Enrollment Period will be held during a thirty-one (31) day period prior to the Policy Anniversary Date of the program. Specify start of annual Open Enrollment Period: _____.

6. **The minimum standard limiting age for covered Dependent children is twenty-six (26) years.** Hereafter, a Dependent Child, Child or Children means a natural child, a stepchild, a medical support order child, an eligible foster child, an adopted child (including a child for whom the Employee or their spouse is a party in a suit in which the adoption of the child is sought) 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. To be eligible for coverage, a child of an Employee's child must also be dependent upon Employee for federal income tax purposes at the time application for coverage is made.

7. **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. 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 certification review, forms, and previous medical certification approvals.

a. ☒ Disabled Dependent Administration will follow **standard rules.**

A disabled Dependent is eligible to add or continue coverage beyond the limiting age of twenty-six (26). Certification Review is administered by BCBSTX; a Disabled Dependent Certification Form must be submitted to BCBSTX.

(HMO only) Proof of incapacity and dependency may be required within thirty-one (31) days of the child's attainment of the limiting age. Subsequent recertification may occur annually, as required.

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b. ☐ Disabled Dependent Administration will follow **custom rules**. Please make the following selections:

Age: A disabled Dependent is eligible to add or continue coverage beyond the limiting age of twenty-six (26).

Certification Review: Please select one (1) option regarding administration of Certification Review.

☐ Certification Review is administered by BCBSTX; a Disabled Dependent Certification Form must be submitted to BCBSTX.

(HMO only) Proof of incapacity and dependency may be required within thirty-one (31) days of the child's attainment of the limiting age. Subsequent recertification may occur annually, as required.

☐ Certification Review is administered by the Employer; there are no Disabled Dependent Certification Form requirements.

If Certification Review is administered by BCBSTX, please select one (1) option regarding forms:

☐ BCBSTX's Disabled Dependent Certification Form will be utilized.

☐ A custom/other Disabled Dependent Certification Form will be utilized.

If Certification Review is administered by BCBSTX, 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.

CURRENT ELIGIBILITY INFORMATION – NEW BUSINESS OR ADD ON ONLY

Total number of Employees/Subscribers:

1. On payroll _____
2. On COBRA continuation coverage _____
3. With retiree coverage (if applicable) _____
4. Who work part-time _____
5. Serving the new hire 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 (HMO only) LEGISLATIVE ELECTIONS

The following mandated benefit offers are made by HMO in compliance with Texas regulations. Please mark your acceptance or declination. Acceptance may result in a rate adjustment.

In Vitro Fertilization Services

☐ **Accept** – If accepted, benefits for In Vitro Fertilization Services will be provided to the same extent as benefits provided for other pregnancy related procedures. **(Note: If selected, an additional charge will be added to your rates.)**

☐ **Decline** – If declined, no benefits are available.

Speech and Hearing Services

☐ **Accept** – Benefits are paid same as any other illness.

☐ **Decline** – If declined, medically necessary speech therapy is covered on an outpatient basis only. Hearing aid benefit is limited to one (1) hearing aid per ear every thirty-six (36) months.

Development Delay – Certain therapies for children with developmental delays are already included in the HMO plans.

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☒ **NO CHANGES** **(Non-HMO only) LEGISLATIVE ELECTIONS**

The following mandated benefit offers are made in compliance with Texas regulations. Please mark your acceptance or declination.

In Vitro Fertilization Services: Benefits for Medical-Surgical Expense incurred for in vitro fertilization procedures will be the same as for maternity care, provided specific requirements are met.

☐ **Accept** – If accepted, benefits for In Vitro Fertilization Services will be provided to the same extent as benefits provided for other pregnancy related procedures. **(Note: If selected an additional charge will be added to your rates.)**

☐ **Decline** – If declined, no benefits are available for these services.

Speech and Hearing Services: Benefits are available for the services of a physician or other provider to restore loss of or correct an impaired speech or hearing function. This benefit includes coverage for hearing aids.

☐ **Accept** – If accepted, benefits are available for medically necessary services to restore loss of or correct an impaired speech or hearing function, with no benefit maximum on hearing aids.

☐ **Decline** – If declined, benefits are available for medically necessary services to restore loss of or correct an impaired speech or hearing function; however, benefits for hearing aids are limited to one (1) hearing aid per ear every thirty-six (36) months.

Development Delay – Certain therapies for children with developmental delays are already included in the Non-HMO plans.

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☐ **NO CHANGES** **LINES OF BUSINESS**
(Check all applicable products)

Managed Health Care Coverage:

☐ Single Option: PPO Plan _____

☐ Multiple Plan Option:

Select up to four (4) plans. All plans may be PPO or HSA plans. If an HMO is selected, a PPO must also be selected.

Plan 1 _____ **Select Product**
Plan 2 _____ **Select Product**
Plan 3 _____ **Select Product**
Plan 4 _____ **Select Product**

If an HMO plan is selected, indicate additional election(s) below (if applicable):

Additional Benefit Options:

☐ Prescription Drug Program _____
☐ Inpatient Mental Health Care (IPMH) Select IPMH
☐ Durable Medical Equipment Select DME

See **HMO Legislative Elections** for In-Vitro Fertilization and Speech and Hearing Services options.

One hundred percent (100%) of Eligible Employees must reside, live, or work in the service area. The HMO service area includes all counties in Texas.

***If an HMO health plan is selected, please complete the HMO Non-Network Plan Certification (item 2) in the OTHER PROVISIONS section of this BPA.**

If HCA is selected, the HCA BPA with HCA Administrative Services Agreement must be completed, signed, and submitted.

Preferred HSA Vendor: **Select Vendor**
If HealthEquity, Inc. is selected, BCBSTX to send HSA enrollment to HealthEquity, Inc.: ☐ Yes ☐ No
Non-Preferred Vendor: _____

Preferred FSA Vendor: **Select Vendor**
Non-Preferred Vendor: _____

Preferred Health Reimbursement Account (HRA) Vendor: **Select Vendor**
Non-Preferred 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.

☐ **Blue Directions℠** If selected, the Blue Directions Addendum is attached and made part of the Policy

Health Care Management Services:

☐ Wellbeing Management (WBM)

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In-Hospital Indemnity Plan:

☐ IHI

DENTAL BENEFIT PLANS:

Voluntary Group Dental

☐ Plan _____

☒ Dual Option: Plan 1 PDENT Dental High Plan Plan 2 PDENT Dental Low Plan

Employer-Paid Dental

☐ Plan _____

☐ Dual Option: Plan 1 _____ Plan 2 _____

BlueMax Advantage:

☐ Graduated dental benefit max

ANCILLARY COVERAGE:

☒ **Life, Disability, Specified Disease, Accident, Hospital Indemnity or Vision:** If checked, attach separate application for those coverages

COMMENTS: _____

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PREMIUM RATES						
	For Internal Use Only - Blue Star℠ Ben.Agree#: BA0004 Dental High Plan	*For Internal Use Only - Blue Star Ben.Agree#:* BA0005 Dental Low Plan	*For Internal Use Only - Blue Star Ben.Agree#:* _____ _____	*For Internal Use Only - Blue Star Ben.Agree#:* _____ _____	*For Internal Use Only - Blue Star Ben.Agree#:* _____ _____	*For Internal Use Only - Blue Star Ben.Agree#:* _____s _____
1. Employee only:	$34.70	$8.73	$_____	$_____	$_____	$_____
2. Employee plus one (1) dependent (i.e., Employee plus one (1) spouse or one (1) child):	$_____	$_____	$_____	$_____	$_____	$_____
3. Employee plus two (2) or more dependents:	$_____	$_____	$_____	$_____	$_____	$_____
4. Employee plus Spouse:	$69.35	$18.56	$_____	$_____	$_____	$_____
5. Employee plus Child(ren) (i.e., Employee plus one (1) or more children):	$74.41	$20.18	$_____	$_____	$_____	$_____
6. Employee plus Family / Family:	$114.36	$28.97	$_____	$_____	$_____	$_____
7. Other: _____	$_____	$_____	$_____	$_____	$_____	$_____
Single Tier Rate structure - Complete item 1.						
Two Tier Rate structure - Complete items 1. and 6.						
Three Tier Rate structure - Complete items 1., 2., and 3.						
Four Tier Rate Structure - Complete items 1., 4., 5., and 6.						
Indicate "N/A" in any rate field that does not apply.						
Medicare Eligible Rates (When BCBSTX is Secondary Payer)						
Single Coverage:	$_____	$_____	$_____	$_____	$_____	$_____
Family Coverage:	$_____	$_____	$_____	$_____	$_____	$_____

COMMENTS: _____

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HMO PROGRAM
☐ **Yes** ☒ **No**

Account Status: ☐ New Group ☐ Existing Group

Choose One: ☐ Blue Premier℠ HMO ☐ Blue Premier Access℠ HMO ☐ Blue Essentials℠ HMO

Physician Service Charges:
_____% of Claim Payments; $_____ per enrollee per month for health Claim Payments; **or** ☐ N/A

☒ **NO CHANGES** **FUNDING / CONTRIBUTION**

FUNDING ARRANGEMENT:

☒ Premium – Prospective

☐ **(Non-HMO only)** Premium – Prospective Retention (Retro Contingent)

☐ **(Non-HMO only)** Alternative Funding Minimum Premium Program – Prospective Minimum Premium (Retro Contingent). The standard premium and rate information does not apply to alternative funding programs. All information regarding premiums and the payments thereof for alternative funding programs can be found in the mutually agreed upon alternative funding agreement between the Employer and BCBSTX.

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 Participants 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 Participant's effective date falls on the sixteenth (16th) day through the end of the month.

2. The contribution of premium to be paid by the Employer is:

PRODUCT	Employee Only	Employee/Child(ren)	Employee/Spouse	Employee/Family
HEALTH				
Plan 1	% or $	% or $	% or $	% or $
Plan 2	% or $	% or $	% or $	% or $
Plan 3	% or $	% or $	% or $	% or $
Plan 4	% or $	% or $	% or $	% or $
DENTAL				
Plan 1	% or $	% or $	% or $	% or $
Plan 2	% or $	% or $	% or $	% or $

3. **(HMO only)** Grace Period: thirty (30) days – standard

4. Prior written notification by BCBSTX to Employer for change of premium rates is sixty (60) days

5. Additional Information/Comments: _____

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☒ NO CHANGES — BILLING SPECIFICATIONS

Employees Listed: ☒ alphabetically ☐ by location
If by location, list locations including location numbers if applicable: _____

Sort by: ☐ Unique Identification Number **(standard)**
☒ Social Security Number

Billing format:
(complete only if special billing requirements are needed)

- ☐ Benefit Agreement
- ☐ Also, Page Break
- ☐ Categories
- ☐ Multiple Billing Profiles
  Explanation: _____

Premium Delay:
(Underwriter approval required for options other than zero (0) day delay)

- ☒ Zero (0) day delay **(standard)**
- ☐ Thirty (30) day delay
- ☐ Sixty (60) day delay
- ☐ Ninety (90) day delay

☒ NO CHANGES — ID CARD DELIVERY

Mail ID Cards to:

- ☐ Account
- ☒ Member's home **(standard)**
  Note: if an HMO plan is selected, HMO ID cards must be mailed to the Member's home

☐ NO CHANGES — OTHER PROVISIONS

1. **Electronic Issuance**: Delivery of insurance documents, including but not limited to the GAD, BPA, Benefit Booklet, SBC and other required forms and amendments thereto, will be delivered via an electronic file or access to an electronic file to the Employer for delivery of applicable documents to each Employee. The Employer agrees that it is solely responsible for providing each Employee access to the most current version of any E-file Benefit Booklet, amendment, or other revised form provided by BCBSTX, or to provide a paper copy of the same to an Employee upon request. The Employer is solely responsible and holds BCBSTX harmless from any misuse of the E-file provided by BCBSTX. You can request paper delivery of insurance documents by opting-out below. You may also go back to paper delivery at any time with no penalty. To change your preferences, contact your Account Executive. Your documents can be viewed or printed using your computer or mobile device that supports mobile browsing. If the method to access electronic files is revised, BCBSTX will notify you and give an opportunity to request paper delivery. Notice of cancellation or termination of a policy will be delivered both electronically and in paper form.

   ☐ Opt-Out – Employer declines to receive electronic versions of insurance documents.

2. **(HMO only) HMO Non-Network Plan Certification:** The Texas Insurance Code mandates HMOs whose network-based delivery system of coverage is the only health benefit coverage being offered under an Employer's health benefit plan must offer all Eligible Subscribers the opportunity to obtain other health coverage through a non-network plan at the time of enrollment and at least annually.

   The non-network coverage required by law may be provided through a point-of-service contract, a preferred provider benefit plan, or any coverage arrangement that allows an Employee to access services outside the HMO's or limited provider network's delivery network. New and renewing groups who refuse to offer or certify that they offered a non-network plan concurrent with the HMO-only will not be allowed to purchase or renew coverage through BCBSTX. To comply with the provisions of this mandate, BCBSTX requests Employer groups certify a non-network plan will be offered to Eligible Subscribers.

   Describe Non-Network Product Offered: _____
   Authorized Company Official's Initials: _____

3. **EHB Election:** Employer elects EHBs based on the Texas benchmark.

4. This BPA is incorporated into and made a part of the Policy entered into and agreed upon by BCBSTX and the account.

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

6. **Reimbursement:** It is understood and agreed that in the event BCBSTX makes a recovery on a third-party liability claim, BCBSTX 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.

7. **Third-Party Recovery Vendors and Law Firms Provisions (other than Reimbursement Services)**: BCBSTX 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.

8. **Massachusetts Health Care Reform Act:** If elected below, BCBSTX will provide required written statements of Minimum Creditable Coverage ("MCC") to Participants residing in Massachusetts and submit applicable electronic reporting to the Massachusetts Department of Revenue. Information transmitted will be exclusively based on information provided to BCBSTX by Employer and coverage under the Plan(s) during the term of the Contract. By electing to have BCBSTX 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 BCBSTX is not responsible for verifying nor ensuring compliance with any tax and/or legal requirements related to this service. Employer or its Participants 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 BCBSTX 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.

9. ☐ **Medical and Ancillary Package Pricing:** The rates shown in this Contract 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 Policy Effective Date. If any of the qualifying ancillary coverage (BlueCare Dental, Basic Life, Short-Term Disability, Long-Term Disability, Accident, Critical Illness, Hospital Indemnity and/or Vision product(s)) lapses during this twelve (12) month period, BCBSTX 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 BCBSTX 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 BCBSTX to the terms and conditions of coverage. In no event shall BCBSTX 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 BPA and Group Policy, and Employer represents and warrants that such Form is true, complete, and accurate. If Employer fails to timely provide BCBSTX with any requested grandfathered health plan information, BCBSTX 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 the BPA includes any retiree only plans and/or excepted benefits, then Employer represents and warrants that one (1) or more such plans is not subject to some or all of the provisions

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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 BCBSTX to the terms and conditions of coverage. In no event shall BCBSTX 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. Employer shall indemnify and hold harmless BCBSTX 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 inquiries or actions, settlements or judgments brought or asserted against BCBSTX in connection with (a) any plan's grandfathered health plan status, (b) any plan's exempt plan status, (c) any directions, actions and interpretations of the Employer, and/or (d) any provision of inaccurate information, and/or (f) Employer's selection of Essential Health Benefit ("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 coverage.

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 coverage and/or administrative services between the parties.

Notwithstanding anything in the Policy or Renewal(s) to the contrary, BCBSTX reserves the right to revise our charge for the cost of coverage (premium or other amounts) at any time if any local, state or federal legislation, regulation, rule or guidance (or amendment or clarification thereto) is enacted or becomes effective/implemented, which would require BCBSTX 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).

Renewals Only: (For the purposes of this Policy, the term "existing BPA" includes, if applicable, the initial Schedule of Specifications and/or Group Agreement signed by the Employer, and any subsequent Schedules of Specifications and/or Group Agreements and amendments thereto.) If this BPA is blank, it is intentional, and this BPA is an addendum to the existing BPA. In such case, all terms of the existing BPA as amended from time to time shall remain in force and effect. However, beginning with the Employer's first renewal date on or after September 23, 2010, the provisions of paragraphs A-C (above) shall be part of (and be in addition to) the terms of the existing BPA as amended from time to time.

Summary of Benefits and Coverage ("SBC"): The SBC Addendum is attached and made a part of the Policy. BCBSTX will create the SBC (only for benefits BCBSTX insures under the Policy) and provide the SBC to the Employer in electronic format. If the Employer approves of the content, Employer will then distribute the SBC to participants and beneficiaries (or hire a third party to distribute) as required by law. If the Employer would like changes to the SBC, it will promptly notify BCBSTX. BCBSTX will also distribute the SBC to participants and beneficiaries via regular hardcopy mail or electronically in response to occasional requests received directly from individuals. All other distribution is the responsibility of the Employer.

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EMPLOYER STATEMENTS:

1. BCBSTX 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 policy based on the enrolled participation and Employer contribution levels;
   - **b)** After the policy 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 if the fifty percent (50%) minimum Employer contribution is not met and/or less than seventy-five percent (75%) of Eligible Employees are enrolled for coverage for six (6) consecutive months.

   BCBSTX reserves the right to change premium rates when a substantial change occurs in the number or composition of Subscribers covered. A substantial change will be deemed to have occurred when the number of Employees/Subscribers 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.

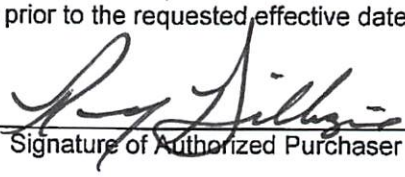
   Employer will promptly notify BCBSTX of any change in participation and Employer contribution.

2. 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 Policy(ies), this BPA or enrollment material in any manner or to adjust any claims for benefits under the Policy(ies).

3. BCBSTX will report the value of all remuneration by BCBSTX to ERISA plans with one hundred (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 one hundred (100) participants. Reporting will include base commissions, bonuses, incentives, or other forms of remuneration for which your agent/consultant is eligible for the sale or renewal of self-funded and/or insured products.

4. 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 Policy into which this BPA shall be incorporated at the time of acceptance by BCBSTX. Upon acceptance, BCBSTX shall issue a Contract to the Employer and the Employer shall be referred to as the "Employer or Policyholder" (Non-HMO) and "Group" (HMO) in the Contract.

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

Amy Westendorf	
Authorized BCBSTX Representative	Signature of Authorized Purchaser
Account Executive	Personnel Director
Title	Title
	10/15/2024
Date	Date
Agent Representative (if applicable)	

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PROXY (OPTIONAL)

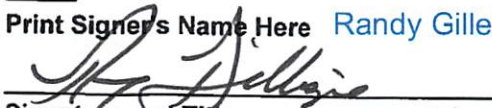
The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC"), or any successor thereof , with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on 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 Randy Gillespie



Personnel Director

Signature and Title ➡

Group Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Dated this 15th day of October 2024
Month Year

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BlueCross BlueShield of Texas

Consumer Choice Plan Disclosure Statement

This health plan does not include the same level of benefits required in other plans.

This HMO plan is a consumer choice plan. This plan doesn't include the same level of benefits that are in Texas health plans known as state-mandated plans. This plan does include all health benefits required by the Affordable Care Act.

To see all benefits offered by this plan, go to the plan's "Summary of Benefits and Coverage."

Benefit/coverage:	This plan:	A health plan with required benefits (state-mandated plan):
Deductible The amount you pay for care before the plan begins to share the cost.	Has a deductible.	Has no deductibles for participating provider care.
Out-of-Pocket Costs The amount you pay when you receive covered services, up to a calendar year maximum.	Includes out-of-pocket costs that meet federal requirements but may sometimes be more than in a state-mandated plan.	A copay must be less than 50% of the total cost of the service. Annual out-of-pocket costs must be capped at 200% of your annual premium cost if you alert the plan.
Habilitative and Rehabilitative Care Care that helps you improve skills for daily living.	Includes a limit on the number of visits per year for speech therapy, occupational therapy, physical therapy and chiropractic care. Limits do not apply for the treatment of acquired brain injury and autism spectrum disorder.	Has no limits on the amount of care if it is needed for medical reasons.
Home Health Services	Includes a limit for home health services.	Has no limits on home health services.
Therapies for Children with Developmental Delays	Does not cover therapies for treatment of developmental delay in children	Covers certain development delay therapies for children with developmental delay, up to age three.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

BlueCross BlueShield
of Texas

If you want a plan with all required benefits:

We also offer a state-mandated plan that includes all required benefits. This plan is not on Healthcare.gov and does not allow you to get help with premiums and out-of-pocket costs. To learn more about this plan, call 1-877-299-2377or visit https://www.bcbstx.com/shop-plans-and-products.

By signing this form, you acknowledge the following:

- I understand the consumer choice plan I am applying for does not provide the same level of coverage required in other Texas health plans (state-mandated plans).
- I understand I can get more information about consumer choice plans from the Texas Department of Insurance's website, https://www.tdi.texas.gov/consumer/consumerchoice.html, or by calling the Consumer Help Line at 1-800-252-3439.

Do not sign this document if you don't understand it.
No firme este documento si no lo comprende.

Signature of Applicant 10/15/2024 **Date**

Randy Gillespie
Name of Applicant (print name)

Johnson County
Name of Business, if applicable

2 N. Main Street
Address

Cleburne Texas 76033
City **State** **Zip**

HMO must give you a copy of this statement upon request.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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, an Independent Licensee of the Blue Cross and Blue Shield Association, hereinafter referred to as the "Claim Administrator" or "BCBSTX"

Group Status: Renewing ASO Account

Employer Account Number (6-digits): 369192 Group Number(s): 369192, 369193, 369194

Section Number(s): _____

Legal Employer Name: County of Johnson

(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

Is your ERISA Plan Year* a period of 12 months beginning on the Effective Date of Coverage specified below? ☐Yes

If not, 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 from drop down ; if applicable, specify other: _____

Is your Non-ERISA Plan Year* a period of 12 months beginning on the Anniversary Date specified below? ☐Yes

If not, 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) 01 / 01 / 2025

Anniversary Date: (Month/Day/Year) 01 / 01 / 2026

Retiree-Only Plan(s) Identification:

For more information regarding Retiree-only plans, contact your Legal Advisor.

Do you have one or more Retiree-only plan(s)? ☐ Yes ☒ No

If yes, please provide Benefit Agreement number, or group and section numbers of the Retiree-only plan(s):

_____

Account Information	☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS	
Standard Industry Code (SIC): 9111	Employer Identification Number (EIN): 756001030	
Address: 2 N Main St., Room 215		
City: Cleburne	State: TX	ZIP: 76033-5500
Administrative Contact: Darla Medford	Title: HR Generalist/ Benefit Coordinator	
Email Address: dmedford@johnsoncountytx.org	Phone Number: 817-556-6349	Fax Number: 817-556-6899
☐ Mailing address is different from primary address		
Mailing Address: 2 N Main St., Room 215		
City: Cleburne	State: TX	ZIP: 76033-5500
Mailing Contact: Randy Gillespie	Title: Personnel Director	
Email Address: randyg@johnsoncountytx.org	Phone Number: 817-556-6149	Fax Number: 817-556-6899
☐ Billing address is different from primary address		
Billing Address: 2 N Main St., Room 215		

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Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator.

City: Cleburne | State: TX | ZIP: 76033-5500

Billing Contact: Laura Baxter | Title: Personnel Assistant

Email Address: laurab@johnsoncountytx.org | Phone Number: 817-556-6162 | Fax Number: 817-556-6899

Wholly Owned Subsidiaries to be covered: _____

Affiliated Companies to be covered: Central Appraisal District | Employer Identification Number (EIN): 751677972

(Affiliated Companies must be required or permitted to be aggregated per IRS Guidelines., Employer hereby confirms that Employer, Subsidiaries and Affiliates are treated as a single employer under Internal Revenue Code Section 414(b), or (c), or (m) or (o), or under applicable law.)

Subsidiary / Affiliate Address: 109 N Main St

City: Cleburne | State: TX | ZIP: 76033-5500

Subsidiary / Affiliate Contact: Darla Medford | Title: HR Generalist/ Benefit Coordinator

Email Address: dmedford@johnsoncountytx.org | Phone Number: 817-556-6349 | Fax Number: 817-556-6899

Blue Access for Employers℠ ("BAE℠") Contact: Darla Medford | Title: HR Generalist/ Benefit Coordinator

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

Email Address: dmedford@johnsoncountytx.org | Phone Number: 817-556-6349 | Fax Number: 817-556-6899

☒ The Employer or other company listed in this BPA is a is a public Entity or governmental agency/contractor

Producer of Record Information ☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

Effective: 10/01/2023

If applicable, the below-named producer(s) or agency(ies) is/are recognized as the Employer's Producer of Record (POR) to act as a representative in negotiations with and to receive commissions from BCBSTX, or Claim Administrator's corporate subsidiaries, as applicable, for procuring Claim Administrator's claims administration services for Employer's employee benefit program(s). 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/Consultant Compensation:

The Employer acknowledges that if its POR 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 POR a commission and/or other compensation in connection with such services under the Administrative Services Agreement. If the Employer desires additional information regarding commissions and/or other compensation paid to the POR by the Claim Administrator in connection with services under the Administrative Services Agreement, the Employer should contact its POR.

Producer or Agency to whom commissions are to be paid*: Holmes Murphy & Associates LLC

Texas Producer #: 000013905 | NPN: 0000765524

Address: 12712 Park Central Drive, Suite 100

City: Dallas | State: TX | ZIP: 75251

Phone: 800-882-5949 | Fax: _____ | Email: jrickman@holmesmurphy.com

Is Producer/Agency appointed with BCBSTX 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*:** _____

Texas Producer #: (nine digits)

NPN: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____ Email: _____

Is Producer/Agency appointed with BCBSTX in Texas? ☐ Yes ☐ No General Agent? ☐ Yes ☐ No

Commissions:

☒ PCPM $0 Does a Monthly Cap Apply ☐ Yes ☐ No $_____ (If cap is annual, divide by twelve)

☐ Flat $_____ Does a Monthly Cap Apply ☐ Yes ☐ No $_____ (If cap is annual, divide by twelve)

☐ Percentage of Stop Loss:_____%

ADDITIONAL COMMISSIONS: _____

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 BCBSTX 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: Part time

2. **Employee definition**:

   Full-Time Employee means:
   - ☒ A person who is regularly scheduled to work a minimum of 30 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.

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☒ Other: The 1st day of the month following or coinciding with 60 days of employement
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 to enroll 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 and/or dependents of domestic partners.

6. **Are unmarried grandchildren eligible for coverage**? ☒Yes (answer the question below) ☐ No
   Must the grandchild be dependent on the employee for federal income tax purposes at the time application is made? ☒ Yes ☐ No

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

8. **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
   **Automatically canceling dependents is not recommended for accounts with automated eligibility*

   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 and the Disabled Dependent provisions of this BPA. The Employer will notify BCBSTX *of any instance where the continuation of disabled dependent coverage is required.*

9. **Disabled dependent:** A disabled dependent means a dependent child who is medically certified as disabled and dependent upon the Employee or his/her spouse. A child is a disabled child when the child is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months, per Internal Revenue Code Section 22(e)(3).

   To administer medical certification of disabled dependents, you may select option (a) Standard Rules or (b) Custom Rules. BCBSTX will administer its standard process for administration of disabled dependent coverage if (a) below is selected by Employer, or at the Employer's direction memorialized below, BCBSTX will follow a customized process if Employer selects (b). If (b) is selected there are additional selections regarding age, proof of prior coverage, certification review, forms, and previous medical certification approvals.

(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 26. A disabled dependent is eligible to ***add*** coverage beyond the limiting age, provided the disability began before the child attained the age of 26, and proof of coverage as a disabled dependent is provided. Administration of certification review is administered by BCBSTX; a disabled dependent certification form must be submitted to BCBSTX.

(b) ☐ Disabled dependent Administration will follow **Custom Rules**. Please make the following sections:

Age: *Please select one option regarding age of when the disability began.*

☐ The disability must have begun before the child attained the age of 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 option regarding the administration of certification review.*
☐ Certification review is administered by BCBSTX; a disabled dependent certification form must be submitted to BCBSTX.
☐ Certification review is administered by the Employer; there are no disabled dependent certification form requirements.

If certification review is administered by BCBSTX, *please select one option regarding forms:*
☐ Utilize BCBSTX's disabled dependent certification forms.
☐ Utilize custom/other disabled dependent certification forms.

If Certification Review is administered by BCBSTX, *please select allowed or not allowed below:*
A disabled dependent approved certification from a prior insurance carrier is ☐ allowed ☐ not allowed.
A disabled dependent approved certification from a prior BCBS policy is ☐ allowed ☐ not allowed.

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 any applicable federal or state law. The Employer will notify BCBSTX *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 group coverage assistance under a state Medicaid or CHIP premium assistance program.

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 otherwise eligible to do so, during the Employer's annual 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: _____

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 otherwise 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.
Select one of the provisions below:
☒ Open Enrollment – Late applicants may only apply during Open Enrollment.
☐ Late Entrant – Late applicants may apply at any time – coverage effective date is determined by the receipt date and allowed rules governing off-cycle enrollments.

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*

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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 probationary period _____
7. declining because of other group coverage (e.g., other commercial group coverage, Medicare, Medicaid, TRICARE/Champus) _____
8. declining coverage (not covered elsewhere) _____

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Lines of Business (Check all applicable services) ☐ NO CHANGES ☐ See *Additional Provisions*

Medical Plan Services:

☒ PPO: Plan Name: PPO Plan
Plan Name: PPO HSA Plan

☒ HMO: Plan Name: HMO Plan

☐ Prescription Drug Option: Select From List

☐ No Prescription Drug Option

☐ Blue High Performance Network℠ (BlueHPN℠)

☐ EPO: Plan Name: _____

☐ POS: Plan Name: _____

Additional Services:

☒ Wellbeing Management
☐ Wellness Incentives
☐ Health Advocacy Solutions
☐ Mercer Health Advantage
☐ Custom Care Management Unit
☐ Blue Directions℠ (Private Exchange) *(If selected, the Blue Directions Addendum must be attached and made a part of the parties' Administrative Services Agreement.)*
☐ In-Hospital Indemnity (IHI)
☒ Limited Fiduciary Services for Claims and Appeals
☒ Other Benefits Value Advisor
☐ Other Select Product
☐ Other
☐ Other

Consumer Driven Health Plan

☐ BlueEdge℠ HCA, *(if selected, complete separate HCA Benefit Program Application)*
☒ BlueEdge℠ HSA, (Preferred Vendor: Select Vendor)* If HealthEquity, Inc. is selected, BCBSTX to send HSA enrollment to HealthEquity, Inc ☐ Yes ☐ No Non-Preferred Vendor: PlanSource
☐ FSA (Preferred Vendor: Select Vendor)* Non-Preferred Vendor:
☐ HRA (Preferred Vendor: Select Vendor)* Non-Preferred Vendor:

Traditional Coverage:

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

Prescription Drugs:

☒ *(If selected, the PBM Fee Schedule Addendum must be attached and is part of this BPA.)*
Pharmacy Network (Select one):
☒ Traditional Select Network
☐ Advantage Network
☐ Preferred Network
☐ Elite Network
☐ Network on PBM Fee Schedule Addendum
☐ Other (please specify):

Drug List: Balanced Drug List

Other (please specify):
PPO/HSA Preventive Drug List:
Please specify: Select Option
Other Rx programs:
Please specify: Select Program

Ancillary Services:

☐ Vision Insurance *(if selected, complete a separate application)*
☒ Stop Loss Coverage (*If selected, complete separate Application and Policy Schedule for Stop Loss Coverage*)
☐ Life, Disability, Specified Disease, Accident or Hospital Indemnity Insurance (*If selected, complete a separate application for those coverages*)
☐ COBRA Administrative Services (*If selected, complete separate HCSC COBRA Administrative Services Addendum)*
☐ Dental Plan Services
Plan Name: _____ Select From List

*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.

Mercer Health Advantage is offered by Mercer, an independent company, and is administered by Blue Cross and Blue Shield of Texas.
Custom Care Management Unit is offered by Willis Towers Watson, an independent company, and is administered by Blue Cross and Blue Shield of Texas.
Medical and Dental benefits and services are administered by Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.
Life, Disability, Specified Disease, Accident, Hospital Indemnity and Vision Insurance is underwritten by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Blue Cross and Blue Shield of Texas is the trade name of Dearborn Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

FEE SCHEDULE

Employer shall pay amounts Claim Administrator bills Employer for benefit claims Claim Administrator processes on Employer's behalf as well as administrative fees as set forth in this 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** (cannot be selected if Check is selected as payment method above)

☒ **Monthly**

Claim Settlement Period: ☒ **Weekly** ☐ **Monthly**

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

Fee Schedule Period: To begin on Effective Date of Coverage and continue for 12 months. If other than 12 months, please specify: months.

Administrative Per Employee per Month (PEPM) Charges ☐ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

	2025	2026	2027	
Administrative Fee	$38.42	$40.26	$42.16	$_____
Dental	$_____	$_____	$_____	$_____
Claims Fiduciary	$1.00	$1.00	$1.00	$_____
Advanced Payment Review	25% $	25% $	25% $	% $
*Medical Drug Rebate Credit	$(2.50)	$(2.50)	$(2.50)	$(_____)
*Rebate Credit for the Prescription Drug Program	$(72.93)	$(72.93)	$(72.93)	$(_____)
Telehealth (Virtual Visits)	$0.52	$0.52	$0.52	$_____
Wellbeing Management	$4.95	$4.95	$4.95	$_____
Health Advocacy Solutions	$_____	$_____	$_____	$_____
Commissions: _____	$_____	$_____	$_____	$_____
Commissions: _____	$_____	$_____	$_____	$_____
Commissions: _____	$_____	$_____	$_____	$_____
Other: Benefits Value Advisor List Service: _____	$2.50	$2.50	$2.50	$_____
Other: Other Services List Service: _____	$_____	$_____	$_____	$_____
Other: Other services List Service: EAP	$1.90	$1.90	$TBD	$_____
Miscellaneous: _____	$_____	$_____	$_____	$_____
Miscellaneous: _____	$_____	$_____	$_____	$_____
Total	$(26.14)	$TBD	$TBD	$_____

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*The Rebate Credit is a per Covered Employee per month credit applied to the monthly billing statement. The Employer and Claim Administrator have agreed to the Rebate Credit and Employer agrees that it and its group health plan have no right to, or legal interest in, any portion of the rebates, either under the pharmacy benefit or the medical benefit, actually provided by the Pharmacy Benefit Manager ("PBM") or a pharmaceutical manufacturer to Claim Administrator and consents to Claim Administrator's retention of all such rebates. The Rebate Credit will be provided from Claim Administrator's own assets and may or may not equal the entire amount of rebates actually provided to Claim Administrator by the PBM or expected to be provided. Rebate Credits shall not continue after termination of the Prescription Drug Program. Employer agrees that any Rebate Credit provision in the governing Administrative Services Agreement to the contrary is hereby superseded.

Administrative Line Item Charges ☐ **SEE ADDITIONAL PROVISIONS**	**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: _____	$_____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	_____%
	Total:	$_____

Other Service and/or Program Fee(s) ☒ **NO CHANGES** ☐ **SEE ADDITIONAL PROVISIONS**

NSA Fees

In connection with the claims, items, and services that are subject to the No Surprises Act ("NSA") and disputed by a Provider, Employer agrees to pay Claim Administrator the following fees:

- Fifty dollars ($50) for each claim that is the subject of informal negotiation with a Provider (this fee will be charged in the event the Provider, in its sole discretion, determines that it will not accept the initial payment amount); and
- An additional seventy-five dollars ($75) per claim for each independent dispute resolution process ("IDR") where Claim Administrator represents Plan (this fee will be charged in the event the Provider, in its sole discretion, determines that it will initiate IDR after the informal negotiation period); and

All costs imposed by the IDR entity or any state, federal or local government entity in connection with an IDR.

Not applicable to Grandfathered Plans

External Review Coordination: ☒ Yes ☐ No

If yes, coordination fee: $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. Employer elects for external reviews to be performed under the Affordable Care Act external review process.

If no, provide name and address of administrator(s) of external review coordination and indicate if administrating medical claims and/or pharmacy claims:

Administrator: Medical claims: ☐ Pharmacy claims: ☐ Name: Mailing Address:
Administrator: Medical claims: ☐ Pharmacy claims: ☐ Name: Mailing Address:

Proprietary and Confidential Information of Claim Administrator
Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator.

Advanced Payment Review (APR): ☒ Yes ☐ No

APR is a suite of payment integrity offerings. Refer to the Matrix. If Employer elects APR, indicate APR Savings Program or PEPM below:

☒ APR Savings Program

☐ PEPM

For APR capabilities other than Reimbursement Services: If Employer elects APR Savings Program, Claim Administrator will invoice the percentage indicated in the Fee Schedule of any savings amounts identified by Claim Administrator or third-party.

Reimbursement Services: ☒ Yes ☐ No If yes, Claim Administrator will retain twenty-five percent (25%) of any recovered amounts made on third-party liability claims other than recovery amounts received as a result of or associated with any Workers' Compensation Law.

FlexAccess™: ☐ Yes ☒ No

As part of its plan design, Employer has directed Claim Administrator to administer claims, copay and coinsurance requirements for Covered Persons enrolled in the FlexAccess program, including (i) adjusting Covered Persons' copayment amounts to the amount of the manufacturer copay assistance, (ii) applying such manufacturer assistance to reduce Covered Persons' out of pocket costs, and (3) not applying the manufacturer assistance to Covered Persons' deductibles and out of pocket maximum accumulators. Employer agrees that FlexAccess is a plan design decision of Employer and is consistent with Employer's plan design and supported by plan documents. Employer further agrees it is solely responsible for, and will hold Claim Administrator harmless for, the legal and regulatory compliance of the Plan and its plan design.

Claim Administrator will assess a program fee equal to 20% of the total shared savings. Total shared savings is calculated as follows:

The difference between Employer responsibility without the FlexAccess Program and Employer responsibility with the FlexAccess Program. The Employer responsibility with the FlexAccess Program is cost of the drug minus: (1) the manufacturer copay assistance dollars that are allocated to the cost of the drug and (2) the member's cost share for the member enrolled in the program. The Employer responsibility without the FlexAccess Program is the cost of the drug minus the member cost share if the member was not enrolled in the program.

FLEXACCESS™ QUALIFIED HDHP: ☐ Yes ☒ No

Claim Administrator will assess a fee equal to 20% of program savings for administrative fees. Program savings (shared savings) will be calculated based on the manufacturer copay assistance dollars that are allocated to the cost of the drug minus the member's estimated cost share (copay or coinsurance) that would have been paid if they were not enrolled in the program.

The difference between Employer Responsibility for claims utilizing FlexAccess Qualified HDHP and not utilizing FlexAccess Qualified HDHP includes as follows:

WITH FLEXACCESS QUALIFIED HDHP: Cost of drug – amount manufacturer copay assistance used – Member out-of-pocket cost (if any) up to Deductible... Copay assistance reversed from deductible. Plan pays no portion.

WITHOUT FLEXACCESS QUALIFIED HDHP: Cost of drug – member out-of-pocket cost - Non-FlexAccess Qualified HDHP coupon... Copay assistance applied to Deductible. Plan may pay portion of claim after deductible met

Third-Party Law Firms Provisions (other than Reimbursement Services): Employer will pay no more than 35% of any recovered amount made by Claim Administrator's third-party law firm or up to 35% of any recovered amount will be deducted from the amount distributed according to established allocation processes.

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 between the Claim Administrator and the Employer.

Virtual Visits Program: ☒ Yes ☐ No If yes, Covered Persons would be able to obtain certain Covered Services remotely via interactive video and/or interactive audio/video (where available) capability from Virtual Visits powered by MDLIVE.

MDLIVE® is a separate company that operates and administers Virtual Visits for persons with coverage through Blue Cross and Blue Shield of Texas. MDLIVE is solely responsible for its operations and for those of its contracted providers. MDLIVE® and the MDLIVE logo are registered trademarks of MDLIVE, Inc., and may not be used without permission.

Termination Administrative Charges				
As applies to the Run-Off Period indicated in the Payment Specifications section above: 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. In the event of a partial termination, the Termination Administrative Charge shall be the sum of the amount obtained by multiplying three (3) times the total number of terminated Covered Employees by the appropriate factors shown below.				
Service	**2024**			
Medical Run-off Administration Charge	**$10.19**	$____	$____	$____
Dental Run-off Administration Charge	$____	$____	$____	$____
Miscellaneous	$____	$____	$____	$____
Miscellaneous	$____	$____	$____	$____
Total:	**$10.19**	$____	$____	$____

Other Provisions

☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

1. **Summary of Benefits & Coverage**:
   a. Will Claim Administrator create Summary of Benefits and Coverage (SBC)?
      ☒ Yes. (Please answer question b. The SBC Addendum is attached.)
      ☐ No. (If No, then skip question b and refer to the Administrative Services Agreement for further information.)
   b. Will Claim Administrator distribute the (SBC) to Covered Persons?
      ☐ No. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Administrative Services Agreement) and provide SBC to Employer in electronic format. Employer will then distribute SBC to Covered Persons (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 Administrative Services Agreement) and distribute SBC to Covered Persons via regular hardcopy mail or electronically. Distribution Fee for hardcopy mail is one dollar fifty cents ($1.50) per package.

2. **Massachusetts Health Care Reform Act**:
   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? ☐ Yes ☐ No

   If no: The Employer acknowledges (1) it will provide written statements and electronic reporting to the Massachusetts Department of Revenue if required by the Massachusetts Health Care Reform Act or (2) that it does not believe it is subject to the notification and reporting requirements of the Massachusetts Health Care Reform Act.

3. **Alternative Care Management Program** (applicable to the purchased medical management program):
   ☐ Yes ☒ No
   The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons for Utilization Management, Case Management, including but not limited to Behavioral Health, and other health care management programs.

4. **Prior Authorization** (applicable to the purchased medical management program): Employer acknowledges and agrees to utilize Claim Administrator's standard list of services and supplies for which Prior Authorization (also called pre-notification or preauthorization) is required.

5. **Essential Health Benefits ("EHB") Election**:
   Employer elects EHBs based on the following:
   1. ☒ EHBs based on a Claim Administrator state benchmark:

☐ Illinois ☐ Montana ☐ New Mexico ☐ Oklahoma ☒ Texas

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 BPA is binding on both parties and is incorporated into and made a part of the Administrative Services Agreement between the parties with both such documents to be referred to collectively as the "Administrative Services Agreement" unless specified otherwise.

8. Independent Dispute Resolution Process:
Employer authorizes and directs Claim Administrator to offer an amount not to exceed the greater of the Qualifying Payment Amount (QPA) or the amount allowed on the initial notice of payment or denial of a claim on behalf of the Employer during negotiations under the federal IDR process.

Additional Provisions: BCBSTX will prodivde an annual transition credit of $30,000 beginning 10/01/2023 (AD Change credit remaining to be paid out on 01/01/2025, 01/01/2026 and 01/01/2027) and continuing for 5 years at each renewal for a total of $150,000 in funding, to be used to cover costs and and expenses associated with transitioning medical, prescription, stop loss, ancillary health or other coverage to BCBSTX and/or costs and expenses associated with transitioning to a new product design with BCBSTX. If employer cancels before expiration of the policy period, Employer will be responsible for refunding to BCBSTX the full amount of the transition credit.

The medical administrative fee shown in this BPA reflects a volume-based discount in an amount equal to $1.00 PEPM of the medical administrative fee for the twelve-month period beginning on the contract effective date for the purchase of a dental coverage from BCBSTX

Signature

Amy Westendorf

Sales Representative

District Phone & FAX Numbers

Producer Representative

Producer Firm

Producer Address

Producer Phone & FAX Numbers

Producer Email Address

Tax I.D. No.

Signature of Authorized Purchaser

Randy Gillespie

Print Name

Personnel Director

Title

10/15/2024

Date

Proprietary and Confidential Information of Claim Administrator
Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator.

PROXY

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members is scheduled to be held each year in the HCSC corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice provided to the member not less than thirty (30) nor more than sixty (60) days prior to such meetings. This proxy shall remain in effect until either 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 its directors, officers, employees or agents consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

☐ Intentionally left blank by the Employer

Group No.: _____ By: Randy Gillespie
Print Signer's Name Here

➡ _____ Personnel Director
Signature and Title

Group Name: _____

Address: 2 N. Main Street

City: Cleburne State: Texas ZIP: 76033

Dated this 15th day of October 2024
Month Year

Proprietary and Confidential Information of Claim Administrator
Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator.

BlueCross BlueShield of Texas

APPLICATION AND POLICY SCHEDULE FOR STOP LOSS COVERAGE

Employer Group Name:	County of Johnson		
Employer Group Address:	2 N Main St Room 215		
City:	Cleburne	**State of Situs:** TX	**Zip Code:** 76033
Account Number:	369192		
Employer Group Number(s):	369192, 369193, 369194		
Original Effective Date of Stop Loss Policy	10/01/2023		
Current Policy Effective Date:	01/01/2025		

Current Policy Period The specifications set forth in this Application are for the Policy Period commencing on 01/01/2025 and ending on 12/31/2025.

The specifications below shall become effective on the first date of the Policy Period specified above and shall continue in full force and effect until the earliest of the following dates: (1) The last day of the Policy Period; (2) The date the Policy terminates; or (3) The date this Application is superseded in whole or in part by a later executed Application.

A. Covered Employees:

Number of Single Coverage Units:	596
Number of Family Coverage Units:	166

B. Individual Stop Loss Coverage:

1. New Coverage ☐ Renewal of Existing Coverage ☒

2. Stop Loss coverage during the Current Policy Period

   ☒ **12/12**

   Coverage for Claims incurred from 01/01/2025 to 12/31/2025 and Claims paid from 01/01/2025 to 12/31/2025.

   If 24/12, 18/12, 15/12, or 12/12 are selected, Employer Group understands that run-out coverage is not included, and Employer Group represents that it intends to purchase run-in coverage from its next carrier.

   For new coverage only, if a run-in contract as explained in the Stop Loss Policy (24/12, 18/12, or 15/12 coverage period) is purchased, claims paid by the Employer Group's prior claim administrator will be settled at the time of the annual stop loss settlement and must be reported by the Employer Group to the Company (Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) by the end of the Employer Group's Current Policy Period or stop loss coverage for these run-in claims will be forfeited.

   ☐ (Paid Renewal Only) Claim Administrators Claims: Claims incurred on or after the Original Effective Date of Policy and paid during the Policy Period.

3. Covered Expenses includes:

   ☒ Medical Claims:
   ☒ Prescription Drug Claims with: Prime (Preferred PBM) _____

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☐ For **Hospital Employer Groups only:** Excludes _____% of Home Hospital Medical claims
☐ Other (for example Dental/Vision): _____.

4. Individual Stop Loss Provisions

a. Individual Stop Loss Deductible: $125,000
Applies per Covered Person for the Employer Group's Current Policy Period.

b. Aggregating Specific Deductible (if applicable): $_____

c. Lasered Individuals with Individual Stop Loss Deductible (if applicable):
Individual identifier, alternate Individual Stop Loss Deductible:
$_____

d. Lasered Individuals excluded from Stop Loss Coverage (if applicable):
Individual identifier:

_____

e. If a run-in contract (24/12, 18/12, or 15/12 coverage period) is purchased, per Item 2. above, run-in claims are covered with a maximum liability of: $_____ per Covered Person.

5. Terminal Liability Option (TLO) (does not apply to Employer Groups with 12/15, 12/18, or 12/24 contracts):
☒ Yes ☐ No

The following applies if the answer to item above is "Yes" (Terminal Liability Option):

Must be elected at Policy inception or renewal. Premium cost is calculated by taking the average enrollment for the last two months of the Current Policy Period multiplied by three times pre-termination Individual Stop Loss rate(s). Premium is due at the time of termination, payable by lump sum within 10 days of receipt of bill. Claims will accumulate and be combined under one Individual Stop Loss Deductible specified in item B.4.a above for the Current Policy Period and Terminal Period. The Settlement for the Final Accounting Period will be described in the section of the Policy entitled SETTLEMENTS.

6. Individual Stop Loss Premium
Monthly Individual Stop Loss Premium shall be equal to the amounts obtained by multiplying the number of Covered Employees for a particular Month by:

$197.09 Composite; or
$_____for each Single Coverage Unit
$_____ for each Family Coverage Unit

C. Aggregate Stop Loss Coverage: Yes ☒ No ☐
If yes, complete Items 1. through 5. Below:

1. New Coverage ☐ Renewal of Existing Coverage ☒

2. Stop Loss Coverage during the current Policy Period

☒ **12/12**

Coverage for Claims incurred from 01/01/2025 to 12/31/2025 and Claims paid from 01/01/2025 to 12/31/2025.

If 24/12, 18/12, 15/12, or 12/12 are selected, Employer Group understands that run-out coverage is not included, and Employer Group represents that it intends to purchase run-in coverage from its next carrier.

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For new coverage only, if a run-in contract as explained in the policy (24/12, 18/12, or 15/12 coverage period) is purchased, claims paid by the Employer Group's prior claim administrator will be settled at the time of the annual stop loss settlement and must be reported by the Employer Group to the Company (Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) by the end of the Employer Group's Current Policy Period or stop loss coverage for these run-in claims will be forfeited.

☐ (Paid Renewal Only) Claim Administrators Claims: Claims incurred on or after the Original Effective Date of Policy and paid during the Policy Period.

3. Covered Expenses:

☒ Medical Claims
- ☐ Claim Administrator's Provider Access Fees

☒ Prescription Drug Claims with: Prime (Preferred PBM) _____
☐ For **Hospital Employer Groups only:** Excludes _____% of Home Hospital Medical claims
☐ Other (for example Dental/Vision): _____

4. Aggregate Claim Liability

a. Attachment Factor 125% of the Average Claim Value
b. Aggregate Claim Factors:

Group Number:	ALL			
Composite; or	$1,478.00	$____	$____	$____
For each Single Coverage Unit	$____	$____	$____	$____
For each Family Coverage Unit	$____	$____	$____	$____

c. Minimum Aggregate Point of Attachment: $12,163,349

5. Terminal Liability Option (TLO) (does not apply to Employer Groups with 12/15, 12/18, or 12/24 contracts):
☒ Yes ☐ No

The following applies if the answer to item above is "Yes" (Terminal Liability Option):

Must be elected at Policy inception or renewal. Premium cost is calculated by taking the average enrollment for the last two months multiplied by three times pre-termination Aggregate Stop Loss rate(s). Premium is due at the time of termination, payable by lump sum within 10 days of receipt of bill.

The Final Settlement Point of Attachment shall equal the sum of the Employer's Aggregate Claim Liability amount for the Policy Period plus 15% of the Aggregate Claim Factor multiplied by 12, and then multiplied by the average enrollment for the last two (2) months of the Current Policy Period immediately preceding termination. Furthermore, for the Final Settlement Period, the Minimum Aggregate Point of Attachment shall be the Minimum Aggregate Point of Attachment in item C.4.c. above increased by 15%. The Settlement for the Final Accounting Period will be described in the section of the Policy entitled SETTLEMENTS.

6. Aggregate Stop Loss Premium:
☒ Monthly Premium
Monthly Aggregate Stop Loss Premium shall be equal to the amounts obtained by multiplying the number of Covered Employees for a particular Month by:
$4.14 Composite; or
$_____ for each Single Coverage Unit
$_____ for each Family Coverage Unit

☐ Annual Premium (Due on the first day of the Current Policy Period): $_____

D. Additional Provisions (if elected):

1. Retirees Covered (select if included):
   Pre-65: ☐ or Post-65: ☐

2. Home Hospital Employer Groups Only: Home Hospital Provider Number(s) subject to exclusion percentage per Item B.3. & C.3.: _____

3. Monthly Aggregate Accommodation: ☐ Yes ☐ No

Additional information: A no new laser rate cap applies to the Individual Stop Loss coverage as follows:
-Applies to the next renewal, effective 01/01/2026.
-The change in Individual Stop Loss premium will not exceed 45%.
-The renewal rate cap excludes changes in contract terms, including but not limited to a change in the individual stop loss contract basis or individual stop loss deductible.
-No new lasers, or an increase in existing lasers, will be applied. Existing lasers may be continued unchanged at HCSC's option.
-Is null and void if enrollment varies +/- 20% or more during the contract period.
-Subject to all terms and conditions outlined in the Policy, the most current Exhibit, and any attachments including but not limited to the proposal/renewal documents.

Fraud Notice: Any person who knowingly, with intent to injure, defraud or deceive any insurance company submits an application containing any false, incomplete, or misleading information, may be subject to prosecution and may be found guilty of a felony under state law and subject to punishment, including fines and/or imprisonment. Submission of false information in connection with this application may also constitute a crime under federal laws. All appropriate legal remedies will be pursued in the event of insurance fraud, including prosecution under Federal Mail or Wire Fraud statutes, and/ or the Federal Racketeer Influenced and Corrupt Organizations Act. Any false statements made herein may be reported to state and federal tax and regulatory authorities as is appropriate.

The undersigned person represents that he/she is authorized and responsible for purchasing Stop Loss Coverage on behalf of the Employer Group. It is understood that the actual terms and conditions of coverage are those contained in this Application and the Stop Loss Coverage Policy into which this Application shall be incorporated at the time of acceptance by Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC"). Upon acceptance, HCSC shall issue a Stop Loss Coverage Policy to the Employer Group. Upon acceptance of this Application and issuance of the Stop Loss Coverage Policy, the Employer Group shall be referred to as the "Policyholder".

Amy Westendorf
Sales Representative

Signature of Authorized Purchaser

Personnel Director
Title of Authorized Purchaser

10/15/2024
Date

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an Independent Licensee of the Blue Cross and Blue Shield Association