



**SMALL EMPLOYER BENEFIT PROGRAM APPLICATION (“BPA”)
(Application for Amendment)**

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

ONLY COMPLETE ITEMS CHANGING

Legal Name of Company changing to: _____	Standard Industry Code (“SIC”): _____	
Request to change Anniversary Date: (1st or 15th): ____/____/____ Month Day Year		
The requested Anniversary Date (1 st or 15 th) may require a Bill Cycle change.		
Employer Identification Number (EIN): _____	Fax Number: _____	Company Telephone Number: _____
Physical Address: Number, Street, City, State, Zip: _____		
Mailing Address: Number, Street, City, State, Zip: _____		
E-Mail Address of Authorized Company Official: _____		
Billing Address (if different from mailing): Number, Street, City, State, Zip: _____		
Billing and Correspondence to the attention of: _____		
Billing Cycle: <input type="checkbox"/> Change billing cycle to the first day of each month through the last day of each month. <input type="checkbox"/> Change billing cycle to the 15th day of each month through the 14th day of the next month.		
Billing Method Selection: Please select one of the following billing methods. (If no selection is made, your benefit plan(s) will default with their current billing method) <input type="checkbox"/> Composite Billing <input type="checkbox"/> Age Billing		
The Blue Access [®] for Employers (“BAE”) contact person is the employee authorized by the Employer to access and maintain its account/employee information via BAE. To access and maintain BAE an email address is required. Name and title of BAE contact person: _____ Telephone Number of BAE contact person: _____ E-Mail address of BAE contact person: _____		

1. Will your group utilize Insure Oklahoma subsidies? Yes No

ELIGIBILITY AND EMPLOYEE EFFECTIVE DATE INFORMATION

1. Employer has determined Employees must routinely work ____ (minimum of 24) hours per week in order to be eligible for health/dental coverage under this Group Contract/Agreement.

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

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
 An Independent Licensee of the Blue Cross and Blue Shield Association
 BlueLincs HMO is a Subsidiary of Health Care Service Corporation, a Mutual Legal Reserve Company

2. Select a Waiting Period:

If a person is added to the Group Contract and it is later determined that the Group reported a coverage date earlier than what would apply, based on the Waiting Period and eligibility conditions the Group provided to BCBSOK, BCBSOK reserves the right to retroactively adjust the coverage date for such person.

a. Newly Eligible Persons will become effective on:

- the first day of the contract/participation month following 0 days 30 days 60 days
Employee and dependent Health and/or Dental Benefit Plans will become effective on the first day of the contract/participation month following satisfaction of the Waiting Period and any substantive eligibility criteria.

b. Substantive eligibility criteria.

Provide a representation below regarding the terms of any eligibility conditions (other than any applicable waiting period already reflected above) imposed before an individual is eligible to become covered under the terms of the plan. If any of these eligibility conditions change, you are required to submit a new BPA to reflect that new information.

Check all that apply:

An Orientation Period that:

1) Does not exceed one month (calculated by adding one calendar month and subtracting one calendar day from an employee's start date); and

2) If used in conjunction with a waiting period the waiting period begins on the first day after the orientation period.

A Cumulative hours of service requirement that does not exceed 1200 hours.

An hours of service per period (or full-time status) requirement for which a Measurement period is used to determine the status of variable-hour employees, where the measurement period:

1) Starts between the employee's date of hire and the first day of the following month;

2) Does not exceed 12 months; and

3) Taken together with other eligibility conditions does not result in coverage becoming effective later than 13 months from the employee's start date plus the number of days between a start date and the first day of the next calendar month (if start day is not the first day of the month).

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

3. Domestic Partners covered: Yes No

If yes: A Domestic Partner, as defined in the Certificate of Benefits/Member Handbook, shall be considered eligible for coverage. The Employer is responsible for providing notice of possible tax implications to those covered Eligible Persons with Domestic Partners.

Continuation coverage for Domestic Partners: If Employer elects coverage for Domestic Partners, Domestic Partners are not eligible for continuation coverage under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

4. Are you adding any affiliates and/or subsidiaries? Yes No

If "yes", list name(s), SIC code, and number of Employees: _____

5. Are you being added as an affiliate or subsidiary? Yes No

If "yes", list name, SIC code, and number of Employees: _____

6. Minimum Participation and Employer Contribution:

BCBSOK/BlueLincs reserves the right to: 1) restrict new business enrollment in health insurance coverage to open or special enrollment periods unless the fifty percent (50%) minimum employer contribution is met and at least seventy five percent (75%) of Eligible Persons (less valid waivers) have enrolled for coverage; and 2) review participation and contribution on existing business and non-renew or discontinue health coverage unless the fifty percent (50%) minimum employer contribution is met and at least seventy five percent (75%) of Eligible Persons (less valid waivers) have enrolled for coverage.

If applicable, BCBSOK/BlueLincs 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

Only complete this page if applicant/employer wants to make a change to their Benefit Plan Selections.

BENEFIT PLAN SELECTIONS

Understanding the Plan # Sample Plan #: B718CHC		
Metallic Level	B	Bronze, Silver, Gold, Platinum
Benefit Design	718	705, 712, 718, etc.
Network/Product Name	CHC	CHC = Blue Choice PPO OPT = Blue Options PPO PFR = Blue Preferred PPO ADT = Blue Advantage PPO

Health Products/Benefit Plan Selection:

Please select the benefit design in the left hand column. Up to three selections may be selected in this column. The marketing plan IDs may be selected in the corresponding rows to the right of the benefit designs column. These marketing plan IDs indicate network choices for the specified benefit. A maximum of six network options may be selected.

Please select ALL benefit plans that the group intends to offer, regardless of whether the plans are currently offered or not.

Benefit Design (select up to 3)		Blue Choice PPO	Blue Preferred PPO	Blue Options PPO	Blue Advantage PPO
(select up to 6)					
<input type="checkbox"/>	<u>B703</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<u>B709</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<u>B710</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<u>B711</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<u>B730</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<u>B731</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<u>S701</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<u>S702</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<u>S709</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<u>S710</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<u>S730</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<u>S731</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<u>S732</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<u>S733</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<u>G720</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<u>G721</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<input type="checkbox"/>	<u>G722</u>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<u>G722OPT</u>	<input type="checkbox"/>	
<input type="checkbox"/>	<u>G723</u>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<u>G723OPT</u>	<input type="checkbox"/>	
<input type="checkbox"/>	<u>G730</u>	<input type="checkbox"/>	<u>G730CHC</u>	<input type="checkbox"/>	<u>G730PFR</u>	<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>	<u>G731</u>	<input type="checkbox"/>	<u>G731CHC</u>	<input type="checkbox"/>	<u>G731PFR</u>	<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>	<u>G732</u>	<input type="checkbox"/>	<u>G732CHC</u>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>	<u>G733</u>	<input type="checkbox"/>		<input type="checkbox"/>	<u>G733PFR</u>	<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>	<u>G735</u>	<input type="checkbox"/>		<input type="checkbox"/>	<u>G735PFR</u>	<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>	<u>G740</u>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<u>G740ADT</u>
<input type="checkbox"/>	<u>G741</u>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<u>G741ADT</u>
<input type="checkbox"/>	<u>G743</u>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<u>G743ADT</u>
<input type="checkbox"/>	<u>G744</u>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<u>G744ADT</u>
<input type="checkbox"/>	<u>G745</u>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<u>G745ADT</u>
<input type="checkbox"/>	<u>G746</u>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<u>G746ADT</u>
<input type="checkbox"/>	<u>P710</u>	<input type="checkbox"/>		<input type="checkbox"/>	<u>P710PFR</u>	<input type="checkbox"/>		<input type="checkbox"/>	<u>P710ADT</u>

If HSA/HDHP is selected, provide name of HSA administrator/trustee: _____

(Vendor: **Select Vendor**)

Dental Products/Benefit Plan Selection:

Plan Pairings (Groups 10+)

Contributory

Any one Contributory high option can be paired with any one Contributory low option; DOKHM12 can be freely paired with any true group.

<u>High Option</u>	<u>Low Option</u>
DOKHR01	DOKLR06
DOKHR02	DOKLR07
DOKHR03	DOKLM21

Voluntary

Any one voluntary high option can be paired with any one voluntary low option. DOKHM16 can be freely paired with any one voluntary option.

<u>High Option</u>	<u>Low Option</u>
DOKHR13	DOKLM25
DOKHR22	DOKLM26

Participation Requirements

Contributory >75% participation

>50% employer contribution

Voluntary

>25% participation

<50% employer contribution

Employers are not required to contribute to Voluntary dental plans.

DENTAL PLAN SELECTION

Plan #	Segment
High Coverage Allocation	
<input type="checkbox"/> DOKHR01	Contributory

<input type="checkbox"/>	<u>DOKHR02</u>	Contributory
<input type="checkbox"/>	<u>DOKHR03</u>	Contributory
<input type="checkbox"/>	<u>DOKHR04</u>	Contributory
<input type="checkbox"/>	<u>DOKHM08</u>	Contributory
<input type="checkbox"/>	<u>DOKHM10</u>	Contributory
<input type="checkbox"/>	<u>DOKHM12</u>	Contributory
<input type="checkbox"/>	<u>DOKHR20</u>	Contributory
<input type="checkbox"/>	<u>DOKHR13</u>	<u>Voluntary</u>
<input type="checkbox"/>	<u>DOKHM14</u>	<u>Voluntary</u>
<input type="checkbox"/>	<u>DOKHM16</u>	<u>Voluntary</u>
<input type="checkbox"/>	<u>DOKHR22</u>	<u>Voluntary</u>
<input type="checkbox"/>	<u>DOKHR23</u>	<u>Voluntary</u>
Low Coverage Allocation		
<input type="checkbox"/>	DOKLR06	Contributory
<input type="checkbox"/>	<u>DOKLR07</u>	Contributory
<input type="checkbox"/>	<u>DOKLM11</u>	Contributory
<input type="checkbox"/>	<u>DOKLM21</u>	Contributory
<input type="checkbox"/>	<u>DOKLR24</u>	<u>Voluntary</u>
<input type="checkbox"/>	<u>DOKLM25</u>	<u>Voluntary</u>
<input type="checkbox"/>	<u>DOKLM26</u>	<u>Voluntary</u>

Additional Information: _____

APPLICANT STATEMENTS

- Applicant understands that, unless otherwise specified in the Group Contract/Agreement, only Eligible Persons and their Dependents are eligible for coverage. Applicant further agrees that eligibility and participation requirements have been discussed with the agent and have been explained to all Eligible Persons.
- Applicant agrees to notify BCBSOK/BlueLincs of ineligible persons immediately following their change in status from eligible to ineligible.
- Applicant agrees to review all applications for completeness prior to submission to BCBSOK/BlueLincs. Applicant applies for the coverages selected in this Small Employer BPA and provided in the Group Contract/Agreement and agrees that the obligation of BCBSOK/BlueLincs shall only include the Benefits described in the Group Contract/Agreement or as amended by any Amendments or Endorsements thereto.
- Applicant agrees to pay to BCBSOK/BlueLincs, in advance, the premiums specified in the Group Billing Statement on behalf of each Eligible Person covered under the Group Contract/Agreement.
- Applicant agrees that, in the making of this Application, it is acting for and in behalf of itself and as the agent and representative of its Eligible Persons, and it is agreed and understood that the Applicant is not the agent or representative of BCBSOK/BlueLincs for any purpose of this Application or any Group Contract/Agreement issued pursuant to this Application.

- Applicant agrees to deliver to its Eligible Persons covered under the Group Contract/Agreement individual Certificate of Benefits/Member Handbooks and Identification Cards and any other relevant materials as may be furnished by BCBSOK/BlueLincs for distribution.
- Applicant agrees to receive on behalf of its covered Eligible Persons all notices delivered by BCBSOK/BlueLincs and to forward such notices to the person involved at their last known address.
- Applicant agrees the agent(s) or agency(ies), specified in writing by the Employer as its Agent of Record (AOR) is authorized by the Employer to act as its representative in negotiations with and to receive commissions from BCBSOK/BlueLincs, a division of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company, and HCSC subsidiaries for Employer's employee benefit programs. The AOR is authorized by the Employer to perform membership transactions on behalf of Employer, and is authorized to conduct such transactions through the Employer's web portal known as Blue Access[®] for Employers (BAE). The appointment will remain in effect until withdrawn or superseded in writing by Employer.
- Applicant understands the effective date of termination for a person who ceases to meet the definition of Eligible Person is the end of the coverage period (billing cycle) during which the person ceases to meet the definition of Eligible Person.
- Any reference in the eligibility section of this Small Employer BPA to the waiting period means the waiting period an Employee must satisfy in order for coverage to become effective. Effective January 1, 2014, the selected waiting period must not result in an effective date that exceeds ninety-one (91) days from the date an Eligible Person becomes eligible for coverage.
- Limiting Age for covered children:
Dependent children under age twenty-six (26) are eligible for coverage until their 26th birthday. Dependent child, used hereafter, means a natural child, a stepchild, an eligible foster child, an adopted child or child placed for adoption (including a child for whom the Eligible Person or his/her spouse, or Domestic Partner, if Domestic Partner coverage is elected, is a party in a legal action in which the adoption of the child is sought), under twenty-six (26) years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage, or any combination of those factors. A child not listed above who is legally and financially dependent upon the Eligible Person or spouse (or Domestic Partner, if Domestic Partner coverage is elected) is also considered a Dependent child under the Group Health Plan, provided proof of dependency is provided with the child's application.

A Dependent child who is medically certified as disabled and dependent upon the Eligible Person or his/her spouse (or Domestic Partner, if Domestic Partner coverage is elected) is eligible to continue coverage beyond the limiting age, provided the disability began before the child attained the age of twenty-six (26).

OTHER PROVISIONS:

- **Electronic Issuance (not applicable to BlueLincs):** At the discretion of BCBSOK and with the consent of the Employer, the Employer agrees to receive, via an electronic file or access to an electronic file, a Certificate of Benefits provided by BCBSOK to the Employer for delivery to each Eligible Person. The Employer further agrees that it is solely responsible for providing each Eligible Person access, to the most current version of any e-file Certificate Booklet, SBC, amendment, or other revised form provided by BCBSOK, or to provide a paper copy of the same to an Employee upon request. The Employer is solely responsible and hold BCBSOK harmless from any misuse of the e-file provided by BCBSOK. By providing your consent, you agree to the electronic delivery of your insurance documents. You can go back to paper delivery at any time with no penalty. Your consent will be valid until it is withdrawn up to and including through policy renewals. To change your preferences, contact your Account Executive. Your documents can be viewed or printed using your computer or mobile device that supports most versions of Internet Explorer, Chrome and Firefox.
 - Accept – Employer consents to receive electronic versions of Certificate Booklets and SBC's for covered Employees. Employer may withdraw this consent at any time and request receipt of hard copy versions by contacting their BCBSOK Account Executive.
 - Decline – Employer does not consent to receive electronic versions of Certificate Booklets and SBC's for covered Employees or the Contract and desires BCBSOK to print and distribute hard copy versions.
 Authorized Company Official's Initials: _____ Date: _____
- **Massachusetts Health Care Reform Act:** Notwithstanding anything to the contrary in this BPA, with respect to the Employer's Employees who live in Massachusetts (if any) the Employer represents that it offers the health insurance benefits provided for herein to all full-time Employees, and the Employer will not make a smaller premium contribution percentage to a full-time Employee living in Massachusetts than to any other full-time Employee living in Massachusetts who receives an equal or greater total hourly or annual salary. For purposes of this representation, a

“full-time Employee” is defined by Massachusetts law, generally an Employee who is scheduled or expected to work at least the equivalent of an average of thirty-five (35) hours per week.

- This BPA is incorporated into and made a part of the Group Contract/Agreement.

ADDITIONAL PROVISIONS:

A. Retiree Only Plans and/or Excepted Benefits: If the Small Employer BPA includes any retiree only plans and/or excepted benefits, then Employer represents and warrants that one or more such plans is not subject to some or all of the provisions of Part A (Individual and Group Market Reforms) of Title XXVII of the Public Health Service Act (and/or related provisions in the Internal Revenue Code and Employee Retirement Income Security Act) (an “exempt plan status”). Any determination that a plan does not have exempt plan status can result in retroactive and/or prospective changes by BCBSOK/BlueLincs to the terms and conditions of coverage. In no event shall BCBSOK/BlueLincs 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.

B. Religious Employer Exemption or Eligible Organization Accommodation: Federal regulations currently exempt health insurance coverage from the Affordable Care Act requirement to cover contraceptive services under guidelines supported by the Health Resources and Services Administration (HRSA) (“contraceptive coverage requirement”) if the coverage is provided in connection with a group health plan established or maintained by a “religious employer” as defined in 45 C.F.R. 147.131(a) (“religious employer exemption”). In addition, health insurance coverage provided in connection with a group health plan established or maintained by an organization that qualifies for the “eligible organization accommodation” is also exempt from the contraceptive coverage requirement.

No: If No, Employer does not elect to utilize the religious employer exemption or eligible organization accommodation. In the absence of an affirmative election from Employer of “No” or “Yes” in this Section, the Employer is deemed to have elected this “No” box (and no exemption or accommodation will be applied).

Yes: If Yes, please choose from the following:

Eligible Organization Accommodation. Employer’s Self-Certification(s), or alternative notice permitted by applicable law for its election (and for the election of every other related organization) to utilize the eligible organization accommodation has been or will be provided to BCBSOK/BlueLincs and is incorporated by reference. Employer acknowledges and agrees that BCBSOK/BlueLincs will rely on such Self-Certification(s) or alternative notice.

Religious Employer Exemption. Employer represents and warrants that the following entities are religious employers and qualify for the religious employer exemption: _____

BCBSOK/BlueLincs reserves the right to terminate acceptance of the eligible organization accommodation Self-Certification with advance written notice to the Employer.

In no event will BCBSOK/BlueLincs be responsible for any legal, tax or other ramifications related to the Employer’s elections in this Section B.

C. Employer shall provide BCBSOK/BlueLincs with immediate written notice in the event Employer and/or any of the entities listed above no longer qualify for the religious employer exemption (as they may be amended, replaced or superseded from time to time). Employer shall indemnify and hold harmless BCBSOK/BlueLincs and its directors, officers and employees against any and all loss, liability, damages, fines, penalties, taxes, expenses (including attorneys’ fees and costs) or other costs or obligations resulting from or arising out of any claims, lawsuits, demands, governmental inquires or actions, settlements or judgments brought or asserted against BCBSOK/BlueLincs in connection with (a) any plan’s grandfathered health plan status, (b) any plan’s exempt plan status, (c) religious employer exemption, , (d) any plan’s design (including but not limited to any directions, actions and interpretations of the Employer, and/or (e) any provision of inaccurate information. In no event will BCBSOK/BlueLincs be responsible for any legal, tax or other ramifications related to the Employer’s elections. Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

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

Section 9010(a) of ACA requires that “covered entities” providing health insurance (“health insurers”) pay an annual fee to the federal government, commonly referred to as the Health Insurer Fee. The amount of this fee for a given

calendar year will be determined by the federal government and currently involves a formula based in part on a health insurer's net premiums written with respect to health insurance on certain health risk during the preceding calendar year. This fee will go to help fund premium tax credits and cost-sharing subsidies offered to certain individuals who purchase coverage on health insurance exchanges.

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

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

Notwithstanding anything in the Group Contract/Agreement or Renewal(s) to the contrary, BCBSOK/BlueLincs 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 BCBSOK/BlueLincs to pay, submit or forward, on its own behalf or on BCBSOK/BlueLincs' behalf, any additional tax, surcharge, fee, or other amount (all of which may be estimated, allocated or pro-rated amounts).

The provisions of paragraphs A-D (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.

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

For Employer:

Name of Authorized Company Official (please print)

Title of Authorized Company Official

Signature of Authorized Company Official

City and State of Signing Official

Date