



Independent licensees of the Blue Cross Blue Shield Association

Group Enrollment and Coverage Agreement OSG - continued

Group Exec Initials

Federal Tax ID Number

 -

Previous BCBSM/BCN Coverage? Yes No

If Yes, was policy Group Individual
BCBSM/BCN Cancellation Date

If yes, Former Group Number

Previous Carrier

 / / -

Workers Comp Carrier

Workers Comp Policy Number

Workers Comp Renewal Date

 / /

MA Code

Managing Agent Name

Agent First Name

Agent Last Name

Agent Code

Administrative Contact Person - First Name

Last Name

Administrative Contact Job Title

Owner/Chief Executive - First Name

Last Name

Owner/Chief Executive Phone Number

 - -

Billing Contact - First Name

Last Name

Billing Contact - Job Title

Simply Blue Plan \$2500 including Prescription Drug \$20/\$60/50% \$80min and \$100max RxCM

Simply Blue Group Benefits Certificate, SBD-P \$2500/\$5000, SBD-NP \$5000/10000, SB-CM-P \$2500/\$5000, SBD-NP \$5000/\$10000, SB-PCB, SB-OV \$40, SB-UC \$40, SB-CMT, SB-ET \$250, BMT, ECIP, WP-180, 2+1 Complementary Option, GCP-D, GPC-SAT2, GLE1, PDC, SOCT, TBHD, PD-TTC \$20/\$60/50%/\$80/\$100 RxCM, PD-XED.

Optional Rider

XVA

For Blue Cross Blue Shield use only:

Effective Date

 / /

Rate Renewal Date

 / /

Sales Office Code

Territory Code

SIC Code

County Code

Billing Cycle Date

Inventory Date

 / /

Mail Code

Control Code

Cluster Code

Terms & Conditions

BCBSM will provide health care coverage to the Group subject to the terms of certificate and riders, BCBSM's administrative and underwriting requirements, Group Administrative Guide (Guide), and the following conditions: **Eligibility**

- A sole proprietor or sole shareholder is eligible for coverage as a one subscriber group (OSG) only if the individual: Is a Michigan resident; is a dues paying member of a Sponsoring Association or Chamber of Commerce; is the owner of the business identified on the "Group Name" line on page 1; works at least 30 hours a week in at least 40 weeks out of the calendar year for the business; does not have any eligible employees (as defined by PA88 of 2003) for whom he or she provides or contributes toward any health care coverage; and receives at least 50 percent of his or her taxable income, excluding investment income, from the business, as provided in PA88 of 2003.
 - An individual who is not a sole proprietor or sole shareholder is eligible for coverage as a one subscriber group (OSG) if he or she is the only eligible employee of a small employer group, as defined by PA88 of 2003, who is seeking health care coverage through the employer group health plan. The individual must meet the definition of eligible employee as provided in PA88. The employer must meet BCBSM group eligibility criteria and participation requirements. The group must be a dues paying member of a Sponsoring Association or Chamber of Commerce.
1. This Agreement is effective on the date established by BCBSM, provided all applicable premiums are paid. The term of this Agreement is for a twelve month period beginning on the effective date. This Agreement is renewable for subsequent twelve month periods provided the OSG continues to satisfy all applicable eligibility requirements listed above, terms and conditions in Paragraphs 1-12 of "Terms and Conditions" and in BCBSM's underwriting rules and certificates and riders. If at any time the individual fails to satisfy these terms or conditions, he or she will no longer be eligible to continue this coverage, but may be eligible for group conversion if the terms and conditions of that coverage are satisfied. If OSG or its representative knowingly enrolls an ineligible individual, OSG agrees to indemnify and hold BCBSM harmless against all benefit payments made for such individual and any damages including costs and reasonable attorney fees.
 2. OSG will prepay all premiums for at least a one month period and will also pay all premiums for any retroactive adjustments expressly permitted by BCBSM's underwriting rules. Refunds or retroactive credits of premium payments, or retroactive additions or deletions of members are not otherwise permitted under this Agreement. Except for government mandated surcharges or subsidies, premium rates are guaranteed for the applicable benefit period then in effect. At its discretion, BCBSM may terminate this agreement immediately if premiums are more than thirty (30) days past due, with termination of coverage retroactive to the date through which premiums were paid in full.
 3. If, after enrollment as an OSG, the OSG wishes to provide or pay the cost of BCBSM or non-BCBSM coverage to one or more eligible employees, this coverage shall terminate and the OSG and employee(s) may be eligible for regular group coverage.
 4. OSG will provide BCBSM or its designees all information required to conduct annual underwriting reviews.
 5. This Agreement is between the OSG and BCBSM, an independent corporation licensed by the Blue Cross and Blue Shield Association (BCBSA), an association of independent Blue Cross and Blue Shield Plans, to use the Blue Cross and Blue Shield names and service marks in Michigan. However, BCBSM is not an agent of BCBSA and, by entering into this Agreement, the OSG agrees that it made this Agreement based solely on its relationship with BCBSM or its agents. The OSG further agrees that BCBSA is not a party to, nor has any obligations under this Agreement, and that no obligations are created or implied by this language.
 6. The Group agrees to provide timely and accurate eligibility information, including Medicare status, and to identify all persons subject to the Medicare Secondary Payer statutes and regulations. The Group acknowledges that BCBSM will rely upon the accuracy of all eligibility information the Group provides, and the Group agrees to indemnify and hold BCBSM harmless against loss, claim or action, including costs, penalties and reasonable attorney fees, arising from the provision of inaccurate eligibility information.
 7. A member who disagrees with how a claim was processed normally first completes the BCBSM routine inquiry procedures. A member who is still dissatisfied must exhaust the review processes provided in 2000PA 250 and 251 (MCL 550.1901 et seq.) or in the Employee Retirement Income Security Act of 1974, as applicable and as amended before seeking any other remedies.
 8. Suits arising out of this Agreement, or any certificate or rider, including any suits brought after the exhaustion of the process described in Paragraph 7 above, must be filed within two (2) years after the cause of action arose and in a Michigan court of competent jurisdiction. Exercising any rights described in Paragraph 7 will not extend such two-year period.
 9. Waiver of any breach of this Agreement by a party shall not constitute a waiver of any subsequent breach of this Agreement, nor will the invalidity or unenforceability of any provision affect the remaining provisions.
 10. Notwithstanding anything contained in this Agreement, BCBSM will have no obligation to the OSG for any coverage not specified in the applicable Certificate and Riders, nor for any coverage which the OSG, in whole or in part, contracts with other carriers to provide on behalf of the OSG. The OSG agrees to indemnify and hold BCBSM harmless against any loss, claims, actions, and damages, including costs and reasonable attorneys' fees, which may arise from any coverage not so provided.
 11. This Agreement and any attachments, constitute the entire agreement between the parties and supersede all other agreements, oral or written, regarding the subject matter and may be amended only by a writing signed by both parties.
 12. This Agreement is entered into in the state of Michigan and shall be construed according to the laws of Michigan.
 13. If applicable, member copayment liability for services received while traveling away from home under the BlueCard Program will, in most cases, be calculated at the lower of the provider's billed charges or the negotiated rate BCBSM pays for the other Blue Cross and/or Blue Shield Plan (the "Host Plan"). This negotiated rate may represent either: (i) The actual price paid on the claim, (ii) an estimated price which reflects adjusted aggregate payments expected to result from settlements or other non-claims transactions between the Host Plan and all or a specified group of its health care providers, or (iii) a discount from billed charges representing the Host Plan's expected average savings for all or a specified group of its health care providers. Host Plans using the last two methods may prospectively adjust such prices to correct for over- or under-estimation of past prices. A small number of states, by statute, require Host Plans to use a basis to calculate member copayments which does not reflect the entire savings to be realized or expected on a particular claim. If members receive services in one of these states, their copayment liability will be calculated using these statutory methods. In all cases, members will be advised of the amount of their copayment liability in the Explanation of Benefits Form for the claim.
 14. If the health care coverage is subject to ERISA, the Group, or its designee (other than BCBSM), shall be the Plan Administrator of the health care coverage under ERISA and shall have all of the responsibilities and authority of that position including ensuring compliance with ERISA, preparing and distributing summary plan descriptions, and advising all eligible individuals of: (i) available benefits and any changes in benefits; (ii) termination of coverage for any reason, including the failure to make any payments when due; and (iii) their COBRA rights, if any. The Group delegates the responsibility and discretionary authority to process and pay claims to BCBSM as "claims administrator" and retains all other responsibilities and duties under ERISA not specifically delegated to BCBSM. BCBSM agrees to assume such responsibility and authority, including any responsibility it may have as a "named fiduciary" (as defined under ERISA 402) for purposes of its claims administration duties, to the extent that under the health care coverage and ERISA it meets the definition of a "named fiduciary." As the named claims administrator, BCBSM shall have the power and discretion to construe the terms of this Agreement and to determine all questions pertaining to the administration, interpretation, and application of this Agreement and any Certificates and Riders that involve eligibility for benefits and the payment or denial of claims. In addition, the parties agree that BCBSM shall have the responsibility for ensuring that its claims procedures comply with the Department of Labor's Claims Procedures described in 29 C.F.R. Part 2560 and for handling all levels of appeal.
 15. Upon thirty (30) days written notice, either party may terminate this Agreement for any reason consistent with applicable law. BCBSM may also terminate this Agreement as described in Sections 2 & 3 above.



Independent licensee of the Blue Cross Blue Shield Association.

Pre-existing exclusion period for one subscriber groups

Blue Cross Blue Shield of Michigan one subscriber group coverage requires a 180-day pre-existing exclusion period. This means if you had a medical condition for which medical advice, care, or treatment was recommended or received within 180 days before your enrollment date, we will not pay benefits for services provided to treat that condition for 180 days after your enrollment date. BCBSM will not impose a pre-existing exclusion period for a one subscriber group that relates to pregnancy as a pre-existing condition.

BCBSM will not impose a pre-existing exclusion period for the child of a one subscriber group if the child was covered under **any** creditable coverage within 30 days of birth, adoption or placement for adoption, provided that the child did not experience a break in coverage of more than 62 days between the termination of the creditable coverage and the enrollment date of the one subscriber group coverage. The child must have been adopted or placed for adoption before attaining 18 years of age.

BCBSM will waive the 180-day exclusion period for a one subscriber group if **all** the criteria listed below are met (Note, these criteria are not required for the child of a one subscriber group):

- o Prior to applying for our individual market coverage, you were continuously enrolled in one or more health plans for at least 18 months with no more than a 62-day break. (Coverage may include group health plans, individual health insurance, Medicare, Medicaid, public health plans, military or federal benefit programs, Indian Health Service or other health plans. Freestanding benefit programs such as dental and vision coverage cannot be counted as prior health care coverage.)
- o Your most recent health coverage prior to applying for individual market coverage was through a group health plan. (Please note that even though health coverage might be provided through an association or other organizations, it is considered to be "individual" health insurance if it is not provided through an employer sponsored group health plan. Also, a business owner and spouse are not considered employees of a business if no other employee partakes in the health plan. If this is the case, the health plan cannot be defined as a "group" health plan but is instead an individual health plan.)
- o You elected and exhausted any COBRA coverage for which you were eligible.
- o You are no longer eligible for group coverage and you are not eligible for Medicare or Medicaid.
- o Your prior coverage was not terminated due to nonpayment of premium or fraud.

Please be sure to submit proof of prior coverage with your application.



Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Federal Tax Id

Form for Federal Tax Id with a hyphen and two sets of boxes for digits.

GROUP REIMBURSEMENT POLICY ACKNOWLEDGEMENT

Group Name _____

By signing this document, Group agrees that deductibles, coinsurance, and copayments under

- List of insurance plans: Simply Blue, Simply Blue HSA, Healthy Blue Outcomes, BlueCore Plus, Community Blue Plan 19, Community Blue Plan 20, All BCN plans, except BCN HRA is allowed on BCN deductible products, Any BCBSM prescription drug coverage*, except Flexible Blue plans, Any BCN prescription drug coverage.

* applies to groups under 100 only

will not be reimbursed by any third party administrator, any employer- funded reimbursement arrangement or any fully-insured plan (whether employer or employee funded). Rules for Flexible Spending Accounts (FSAs): Employee-funded FSAs are allowed for all plans. Employer FSA contributions of up to \$250 per contract are allowed, with the following exceptions: BCBSM's Healthy Blue Outcomes and BCN's Healthy Blue Living and Healthy Blue Living Rewards.

Group understands that failure to adhere to this agreement could result in Blue Cross Blue Shield of Michigan or Blue Care Network taking either of the following actions: (1) refuse to renew the group's coverage; or (2) terminate the group's coverage. BCN may adjust the premiums for the coverage.

Group Decision Maker signature _____ Date _____

Group Decision Maker Name (Print) _____

BCBSM Group number/suffixes; BCN Group number/subgroups/classes _____

As agent of this group, in addition to the statement above, I also certify that I am not offering and will not offer or facilitate any of the above described reimbursement arrangements for this customer when the customer has purchased one of the above plans . I understand that failure to adhere to this certification can result in termination of the agent's contract with BCBSM/BCN; nonpayment of commissions; or other penalties identified by BCBSM/BCN.

Agent signature _____ Date _____

Agent name (Print) _____