BlueCross BlueShield of Oklahoma

1400 South Boston • P. O. Box 3283 • Tulsa, OK 74102-3283

BlueLincs
Blue Cross and Blue Shield of Oklahoma

Large (151+) EMPLOYER BENEFIT PROGRAM APPLICATION ("Employer Application")

Blue Cross and Blue Shield of Oklahoma (herein called "BCBSOK")

BlueLincs HMO (herein called "BlueLincs")

(For internal use only)
Account Status: ☐ New ☒ Renewing ☐ Benefit Change ☐ Former ASO (converting to Fully Insured)

Account Number (6-digits): YNS005

Group Number(s): 266585; 266588; 266589; Dental: 266590; 266591; 266592

Section Number(s): 0001, 0002, 0003, 1001, 1002, 1003, 2001, 2002, 2003, 0004, 0005, 0006, 1004, 1005, 1006, 2004, 2005 & 2006

Group Contract Date: 07/01/2023

Group Contract Anniversary Date: 07/01/2024

Employer's Legal Name: City of Lawton

Employer's Legal name will appear on Member ID cards. Thirty-two (32) character spaces are allowed. If variation from Employer's legal name is necessary or desired, please indicate specifics here:
N/A

Requested Group Contract(s) Effective Date (first (1st) or fifteenth (15th)): 07/01/2023 (Month/Day/Year)

Anniversary Date (AD): 07/01/2024

Employer Identification Number (EIN):	Standard Industry Code (SIC):	Company Telephone Number:
73-6005287	_____	(580) 581-3500 Ext. 1315

Primary Mailing Address: Number, Street, City, State, Zip
212 SW 9th Street, Lawton, Oklahoma 73501

Physical Address (required if different from primary): Number, Street, City, State, Zip
Same

Billing Address (if different from primary – If more than one, please list within Additional provisions):
Number, Street, City, State, Zip
212 SW 9th Street, Lawton, Oklahoma 73501

Name and Title of Authorized Company Official: Craig Akard
Email and Phone Number Craig.Akard@lawtonok.gov - Ph: (580) - 581 - 3392

Billing to the attention of:	Fax Number:
Taressa Macias: Email - Taressa.Macias@lawtonok.gov Ph: (580) - 581 - 3392	(580) - 581-3530

The Blue Access for Employers℠ ("BAE℠") contact person is the Employee authorized by the Employer to access and maintains its account/Employee information via BAE. An email address is required to access and maintain BAE.

Name and title of BAE contact person: Craig Akard

Telephone Number of BAE contact person: Ph: (580) - 581 - 3392

E-Mail address of BAE contact person: Craig.Akard@lawtonok.gov

Subsidiary / Affiliated Companies to be covered (If more than one, please list within Additional provisions):
Name and Address Number, Street, City, State, Zip
N/A

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 twelve (12) months beginning on the Anniversary Date specified above? ☐ Yes ☐ No

If No, please specify your ERISA Plan Year (mm/dd/yyyy): Beginning Date 07/01/2023 End Date: 06/30/2024

ERISA Plan Administrator *: N/A

Plan Administrator's Address: N/A

If you maintain that ERISA is not applicable to your Group Health Plan, please give the 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 (complete and attach a Medical Loss Ratio Assurance form)
☐ Other; please specify: N/A

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

If No, please specify your Non-ERISA Plan Year (mm/dd/yyyy): Beginning Date:07/01/2023 End Date:06/30/2024

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

1. Are you applying for Insure Oklahoma? ☐ Yes ☒ No
If Yes, effective date must be the first (1st) of the month to receive subsidies.

☒ NO CHANGES ELIGIBILITY INFORMATION

1. Eligible Person (please check all boxes that apply):

☐ A full-time Employee of the Employer.
☐ A part-time Employee of the Employer.
☐ An Eligible Person may also include a retiree of the Employer. (please specify): N/A
☒ Other (please specify): Persons eligible for coverage under this plan shall include only full-time employees who meet these conditions:

1. Employed by the City on an active, regular full-time basis or part-time basis who are scheduled to work at least thirty (30) hours per week.
2. Actively at work at the customary place of employment and in performance of the regular duties on the effective date of coverage.
3. Employees must remain current with the premiums and contributions during any period for which coverage is provided. Failure to do so will result in loss of coverage.
4. Have applied for coverage
5. Dependent spouse of an employee and Dependent Child(ren) that have not reached the limiting age.

And Retirees that meet the following conditions:

1. Persons who have retired as either regular, disability or early retirees and are receiving pension disbursements from the City of Lawton are eligible to participate in the City-sponsored group health care plan provided the retiree made an election for retiree coverage within 30 days of his/her retirement.
2. If a retired person fails to enroll himself/herself within 30 days of his/her loss of coverage as an active employee he/she and his/her eligible dependents will not be eligible to enroll in the City's plan at any future time.
3. Have applied for coverage at the same level of coverage which the employee had as an active employee.
4. Retiree or surviving spouse must remain current with the premiums and contributions during any period for which coverage is provided. Failure to do so will result in loss of coverage. The City makes no contributions or premiums on the retiree's behalf.
5. Medical only: Retirees who are under the age of 65, Dependent Spouse (of a retiree who is age 65 or older) when said spouse is under the age of 65, Dependent Spouse (of a retiree who is under the age of 65), Dependent Child(ren) (of a retiree who is under the age of 65 or is age 65 or older) that have not reached the limiting age.
6. Dental only: Retirees of any age, Dependent Spouse (of a retiree of any age), Dependent Child(ren) (of a retiree of any age) that have not reached the limiting age.

2. Employer has determined Employees must routinely work 30 (minimum of twenty-four (24)) hours per week and who is on the permanent payroll of Employer in order to be eligible for health/dental coverage under this Group Contract.

3. **Domestic Partners covered**? ☒ Yes ☐ No

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

If yes, are Dependents of Domestic Partners eligible for coverage? ☒ Yes ☐ No

If yes, the Limiting Age for covered children of Domestic Partners means twenty-six (26) years, regardless of presence or absence of a child's financial dependency, residency, student status, employment, marital status, or any combination of those factors.

Continuation coverage for Domestic Partners: If Employer elects coverage for Domestic Partners, Domestic Partners may be eligible for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Employer shall determine eligibility for COBRA continuation for Domestic Partners, if any. Please indicate your election below:

☒ Yes, Employer elects to offer continuation coverage to Domestic Partners, as defined in the Certificate Booklet

☐ No, Employer does not elect to offer continuation coverage to Domestic Partners (Domestic Partners are not eligible for continuation coverage)

☐ Other: N/A

4. **The Effective Date of coverage for a newly Eligible Employee who becomes effective after the Employer's initial enrollment date is**: 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 to the Employee or Dependent, 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.

☐ The date of employment.

☐ The first (1st) billing cycle following the date of employment.

☐ The first (1st) billing cycle following select one days of continuous employment.

☐ The first (1st) billing cycle following select one months of continuous employment.

☐ The select one day of employment

☒ Other (please specify): 1st of the month following 30 days

5. **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 Group Contract. If any of these eligibility conditions change, you are required to submit a new Employer Application 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.

☐ 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: N/A

6. The Effective Date of termination for a person who ceases to meet the definition of Eligible Person will be the end of the coverage period (billing cycle) during which the person ceases to meet the definition of Eligible Person.

☒ Other (please specify): Date of Employment Termination

7. Is the waiting period requirement to be waived on initial Group enrollment? ☒ Yes ☐ No

8. Did you have a waiting period requirement with the prior carrier? ☐ Yes ☒ No

If Yes, please state waiting period requirement of the prior carrier. N/A

9. **Limiting Age for covered children**: Dependent children are eligible for coverage until their twenty-sixth (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 Employee 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 Employee 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.

☐ Other: N/A (indicate maximum age) age twenty-six (26) and over are available options. Please explain any limitations or requirements for extension of coverage beyond the minimum required age of twenty-six (26).

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

10. **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). 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 age, proof of prior coverage, certification review, forms, and previous medical certification approvals.

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

A disabled Dependent may continue coverage beyond the limiting age, provided the disability began before the child attained the age of twenty-six (26). A disabled Dependent may add coverage beyond the limiting age, provided the disability began before the child attained the age of twenty-six (26), and proof of coverage as a disabled Dependent is provided.

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

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

Age: Please select one (1) option regarding age of when the disability began.
☐ The disability must have begun before the child attained the age of twenty-six (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 (1) option regarding administration of Certification Review.
☐ Certification Review is administered by BCBSOK; a Disabled Dependent Certification Form must be submitted to BCBSOK.
☐ Certification Review is administered by the Employer; there are no Disabled Dependent Certification Form requirements.

If Certification Review is administered by BCBSOK, please select one (1) option regarding forms:
☐ BCBSOK's Disabled Dependent Certification Form will be utilized.
☐ A custom/other Disabled Dependent Certification Form will be utilized.

If Certification Review is administered by BCBSOK, 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.

11. Late Enrollment and Open Enrollment:

Late Enrollment*:* An Eligible Person may apply for coverage, coverage to include his/her Dependents or add Dependents if he/she did not apply during his/her Initial Enrollment Period. The Effective Date for such person and/or his/her Dependent(s) will be the next Group Contract Anniversary Date.

☐ Other (please specify): N/A

Open Enrollment: An Eligible Person may apply for coverage, coverage to include his/her Dependents or add Dependents if he/she did not apply during the Initial Enrollment Period, during the Employer's Open Enrollment Period.

Specify Open Enrollment Period:
☐ Thirty-one (31) days immediately preceding the Group Contract Anniversary Date.
☒ Other (please specify): May of 2023

The Effective Date for such person and/or his/her Dependent(s) will be:
☒ The Group Contract Anniversary Date.
☐ A date mutually agreed to by BCBSOK/BlueLincs and the Employer. Such date shall be subsequent to the Open Enrollment Period. (please explain): N/A

12. EHB Election: Employer elects EHBs based on the Oklahoma benchmark.

13. Other Eligibility Provisions (Please explain)
N/A

CURRENT ELIGIBILITY INFORMATION

Total number of Employees (Please indicate the total number of actual Employees, not enrollees):

1. On payroll _____

2. On COBRA continuation coverage _____

3. With retiree coverage (if applicable) _____

4. Who work part-time and are not eligible _____

5. Serving the new hire probationary waiting period (if not waived per #7 above) _____

6. Declining because of other coverage (e.g., other commercial group coverage, Medicare, Medicaid, TRICARE/Champus) _____

7. Declining coverage (not covered elsewhere) _____

CONTRIBUTION AND PARTICIPATION

STANDARD PREMIUM INFORMATION

A. 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.

☐ Other (please specify): N/A.

B. Premium Change Notice:

☒ Thirty-one (31) days (**standard**)

☐ Other (please specify): N/A

C. Health Employer Contribution, the percentage***** of health premium to be paid by the Employer is:

Medical -- % or $		
Employee Only Coverage	N/A%	$TBD
Employee/Spouse Coverage	N/A%	$TBD
Employee/Children Coverage (i.e. Employee plus one or more Children Coverage)	N/A%	$TBD
Family Coverage	N/A%	$TBD
N/A	N/A%	$TBD

*The minimum contribution amount which is required from the Employer is fifty percent (50%) of the premium for Employee Only (Single Coverage).

D. BlueCare Dental℠ Employer Contribution if applicable, the percentage of BlueCare Dental premium to be paid by the Employer is:

Dental -- % or $		
Employee Only Coverage	0%	$N/A
Employee/Spouse Coverage	0%	$N/A
Employee/Children Coverage (i.e. Employee plus one or more Children Coverage)	0%	$N/A
Family Coverage	0%	$N/A
N/A	0%	$N/A

BlueCare Dental minimum contribution amount which is required from the Employer is fifty percent (50%) of the premium for the Employee Only (Single Coverage).

+Voluntary Group Dental product does not require an Employer contribution.

E. **Minimum Participation and Employer Contribution.** BCBSOK/BlueLincs reserves the right to take any or all of the following actions:

1. Initial rates for new Groups will be finalized for the Effective Date of the Group Contract based on the enrolled participation and Employer contribution levels;

2. after the Group Contract 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 (less valid waivers). In the event the Group is unable to maintain the contribution and participation requirements, then the rates will be adjusted accordingly; and/or

3. non-renew or discontinue coverage unless the fifty percent (50%) minimum Employer contribution is met and at least seventy-five percent (75%) of eligible Employees (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 when the number of Employees/Members 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 BCBSOK/BlueLincs of any change in participation and Employer contribution.

Blue Select Dental℠ has specific participation requirements. The Group Contract and endorsements contain the terms and conditions.

☒ No Changes	HEALTH LINES OF BUSINESS	
Please check all products for which you are applying and indicate the applicable health plan or package number(s) (if available) below.		
☐ Blue Choice PPO℠	Additional Blue Choice PPO Plan	☐ Yes ☒ No
☐ Blue Options PPO℠	Additional Blue Options PPO Plan	☐ Yes ☒ No
☐ Blue Options HSA℠ (Vendor: **Select Vendor**)		
☒ Blue Preferred PPO℠	Additional Blue Preferred PPO Plan	☐ Yes ☒ No
☒ Blue Preferred PPO HSA® (Vendor: **HSA Bank**)		
☐ Blue Traditional®		
☐ BlueLincs HMO℠		
☐ HSA Blue℠ Plan # N/A (Vendor:**Select Vendor**)		
☐ Health Care Account (if checked, complete and attach a separate HCA Benefit Program Application)		
☐ FSA (Vendor: **Select Vendor**)		
☐ Health Reimbursement Account (HRA) (Vendor:**Select Vendor**)		
☐ Wellbeing Management (WBM)		
☒ Other Adding Livongo(Diabetes & Hypertension Management Program) Eff 07/01/2022		

☒ No Changes	DENTAL LINES OF BUSINESS
Please check all products for which you are applying and indicate the applicable dental plan or package number(s) (if available) below.	
☐ BlueCare Dental Plan # N/A	
☐ Blue Select Dental Plan # N/A	
☐ Custom Voluntary BlueCare Dental	
☒ Custom Dental Benefits	
☐ Other N/A	

☒ No Changes	VISION LINE OF BUSINESS
Please indicate if vision coverage is elected: ☐ Yes ☒ No If yes, attach separate application for vision coverage.	

☐ **Other Benefit Provisions (Please explain):** N/A

RATES (Per Benefit Agreement if different)							
Select rate structure: ☐ 2-Tier ☐ 3-Tier ☒ 4-Tier ☐ 5-Tier							
PRODUCT/COVERAGE	**EE**	**EE/SP**	**EE/CH**	**Family**	_____	**Medicare Carve-Out**	
						EO	**ES**
Blue Choice PPO	$_____	$_____	$_____	$_____	$_____	$_____	$_____
Blue Options PPO	$_____	$_____	$_____	$_____	$_____	$_____	$_____
Blue Options HSA	$_____	$_____	$_____	$_____	$_____	$_____	$_____
Blue Preferred PPO	$_____	$_____	$_____	$_____	$_____	$_____	$_____
Blue Preferred PPO HSA	$_____	$_____	$_____	$_____	$_____	$_____	$_____
Blue Traditional	$_____	$_____	$_____	$_____	$_____	$_____	$_____
BlueLincs HMO	$_____	$_____	$_____	$_____	$_____	$_____	$_____
HSA Blue	$_____	$_____	$_____	$_____	$_____	$_____	$_____
Dental Low/Mid/High Plans	$Low - $23.50 Mid - $27.96 High - $34.10	$Low - $46.94 Mid - $55.86 High - $68.18	$Low - $51.60 Mid - $61.42 High - $74.96	$Low - $72.06 Mid - $85.76 High - $104.66	$_____	$_____	$_____
Vision	$_____	$_____	$_____	$_____	$_____	$_____	$_____
Custom Benefits PPO Plan I($1,500 Deductible)	$607.56	$1,397.39	$1,336.62	$1,458.14	$_____	$_____	$_____
PPO Plan II($4,000 Deductible)	$551.86	$1,269.28	$1,214.09	$1,324.46	$_____	$_____	$_____
HDHP($5,000 Deductible)	$496.78	$1,142.62	$1,092.91	$1,192.31	$_____	$_____	$_____
	$_____	$_____	$_____	$_____	$_____	$_____	$_____

The above initial monthly premium rates shall be in effect beginning on 07/01/2023, and are subject to change by BCBSOK/BlueLincs after the premium rates are in effect for a period of at least 12 months and/or there is a substantial change in the number of covered Employees.

LEGISLATIVE REQUIREMENTS

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and the **Consolidated Omnibus Budget Reconciliation Act (COBRA)**, as amended, are federally mandated requirements. Employer penalties for noncompliance may apply. It is your responsibility to annually inform BCBSOK/BlueLincs of whether **COBRA** is applicable to you based upon your full and part-time Employee count in the prior calendar year.

Failure to advise BCBSOK/BlueLincs of a change of status could subject you to governmental sanctions.

TEFRA is a Medicare secondary payer requirement that mandates Employers that employ twenty (20) or more total Employees (full-time, part-time, seasonal, or partners) for each working day in each of twenty (20) or more calendar weeks in the current or preceding calendar year to offer the same (primary) coverage to their age sixty-five (65) or over Employees and the age sixty-five (65) or over spouses of Employees of any age that they offer to younger Employees and spouses.

Are you subject to TEFRA? Yes ☐ No ☐

COBRA

a. Did your company employ twenty (20) or more full-time and/or part-time Employees for at least fifty percent (50%) of the workdays of the preceding calendar year? **Yes ☒ No ☐**

b. Are you subject to COBRA? Yes ☒ No ☐

MEDICARE SECONDARY PAYER RULES

Under the **Medicare Secondary Payer Rules**, it is your responsibility to annually inform BCBSOK/BlueLincs of proper Employee counts for the purpose of determining payment priority between Medicare and BCBSOK/BlueLincs. **To satisfy this responsibility at this time, please complete, sign, date, and return the *Annual Medicare Secondary Payer Employer Acknowledgement Form along with this Employer Application*.**

PRODUCER OF RECORD INFORMATION

1. *Primary Producer(s) or Agency(ies): Are commissions to be paid? ☒ Yes ☐ No

Producer Name: John Collins Producer #: _____

Agency Name: Higginbotham & Associates Agency #: _____

Agency Address: Street 500 W 13th Street

City Ft. Worth State Texas Zip 76102

Phone: 817-347-7015 Fax: N/A Email JCollins@Higginbotham.com

Medical Commissions: 2%

Dental Commissions:
☐ Standard
☒ Other: 10%

2. *Producer(s) or Agency(ies): Are commissions to be paid? ☐ Yes ☒ No

Producer Name: N/A Producer #: N/A

Agency Name: N/A Agency #: N/A

Agency Address: Street N/A

City N/A State N/A Zip N/A

Phone: N/A Fax: N/A Email N/A

Medical Commissions:N/A

Dental Commissions:
☐ Standard
☐ Other: N/A

If commission split**, designate percentage for each:
Producer/Agency 1:N/A% Producer/Agency 2: N/A%

3. Other Producer Information:

A. Multiple Location Agency(ies): If servicing agency is not listed above as Item 1 or 2, specify location below: N/A

B. Other: N/A

*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 BCBSOK and/or BlueLincs.

OTHER PROVISIONS:

1. **Life, Disability, Critical Illness or Accident insurance purchased:** ☒ Yes ☐ No
(If yes, complete separate application for those coverages.)

2. **Summary of Benefits and Coverage ("SBC"):** BCBSOK will create the SBC (only for benefits BCBSOK insures under the Group Contract) 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 BCBSOK. BCBSOK 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.

3. **Massachusetts Health Care Reform Act:** Notwithstanding anything to the contrary in this Employer Application, 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.

4. This Employer Application is incorporated into and made a part of the Group Contract.

5. **Transition Credit**: BCBSOK will provide a one-time transition credit of $100,000 for the twelve (12) month period beginning on the Group Contract Effective Date to be used to cover costs and expenses associated with transitioning medical, prescription, ancillary health or other coverage to BCBSOK and/or costs and expenses associated with transitioning to a new product design with BCBSOK. If Employer cancels before the expiration of the Group Contract period, Employer will be responsible for refunding to BCBSOK the full amount of the transition credit.

6. **Wellness Credit:** BCBSOK will provide a one-time wellness credit of N/A for the twelve (12) month period beginning on the Group Contract Effective Date to be used to cover costs and expenses associated with the implementation of a new or to operate an existing wellness program for the benefit of Members. If Employer cancels before the expiration of the Group Contract period, Employer will be responsible for refunding to BCBSOK the full amount of the wellness credit.

7. **Communication Credit**: BCBSOK will provide a one-time communication credit of N/A for the twelve (12) month period beginning on the Group Contract Effective Date to be used to cover costs and expenses associated with Member communications and other communication costs associated with electing coverage through BCBSOK. If Employer cancels before the expiration of the Group Contract period, Employer will be responsible for refunding to BCBSOK the full amount of the communication credit.

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

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

10. ☒ **Medical and Ancillary Package Pricing:** The rates shown in this Agreement 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 Group Contract Effective Date. If any of the qualifying ancillary coverage (BlueCare Dental, Basic Life, Short-Term Disability, Long-Term Disability, Accident, Critical Illness and/or Vision product(s)) lapses during this twelve (12) month period, BCBSOK 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 BCBSOK/BlueLincs 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 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 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 Large Employer Benefit Program Application and Group Contract, and Employer represents and warrants that such Form is true, complete, and accurate. If Employer fails to timely provide BCBSOK/BlueLincs with any requested grandfathered health plan information, BCBSOK/BlueLincs 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 Large Employer Benefit Program Application 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 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.

C. 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 inquiries 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) any directions, actions and interpretations of the Employer, (d) any provision of inaccurate information, (e) the SBC and/or (f) Employer's selection of Essential Health Benefit ("EHB") definition for the purposes of the Patient Protection and Affordable Care Act ("ACA"). Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

Notwithstanding anything in the Group Contract 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 the Employer's 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-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.

The obligation set forth in Section C of the Employer to indemnify and hold harmless BCBSOK/BlueLincs shall apply to the extent allowed under applicable law and shall be subject to the Oklahoma Governmental Tort Claims Act, 51 O.S. Sec. 151 et seq.

EMPLOYER STATEMENTS

1. Employer understands that, unless otherwise specified in the Group Contract, only eligible Employees and their Dependents are eligible for coverage. Employer further agrees that eligibility and participation requirements have been discussed with the agent and have been explained to all Eligible Persons.

2. Employer agrees to notify BCBSOK of ineligible persons immediately following their change in status from eligible to ineligible.

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

4. Employer agrees to pay to BCBSOK, in advance, the premiums specified in the Group Billing Statement on behalf of each Eligible Person covered under the Group Contract.

5. Employer agrees that, in the making of this Employer Application, it is acting for and on behalf of itself and as the agent and representative of its Eligible Persons, and it is agreed and understood that the Employer is not the agent or representative of BCBSOK for any purpose of this Employer Application or any Group Contract issued pursuant to this Employer Application.

6. Employer agrees to deliver to its Eligible Persons covered under the Group Contract individual Certificate of Benefits/Member Handbook and Identification Cards and any other relevant materials as may be furnished by BCBSOK for distribution.

7. Employer agrees to receive on behalf of its covered Eligible Persons all notices delivered by BCBSOK and to forward such notices to the applicable recipient(s) at their last known address.

8. Employer agrees the producer (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 and/or corporate subsidiaries, as applicable, for procuring fully insured coverage for Employer's Employee benefit program(s). 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 BAE. The appointment will remain in effect until withdrawn or superseded in writing by Employer.

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.

Christopher Y. Engelman

Sales Representative

405 N/A 405-316-7011

District Fax No. Phone No.

John Collins

Producer Representative

Higginbotham & Associates

Producer Firm

500 W. 13th Street, Ft. Worth, Texas 76102

Producer Address

BCBSOK Producer No.

Printed Name of Authorized Employer Representative

Signature of Authorized Employer Representative

Title

Date

(NOTE: THE FOLLOWING PROXY INFORMATION IS NOT APPLICABLE TO BLUELINCS HMO.)

PROXY

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.: 266585; 266588; 266589; Dental: 266590; 266591; 266592

By: _____

Print Signer's Name Here

➡ _____

Signature and Title

Group Name: City of Lawton

Address: 212 SW 9th Street

City: Lawton State: Oklahoma Zip Code: 73501

Dated this _____ day of _____
Month Year