BlueCross BlueShield of Florida Health Options®

Health Options and its Parent, Blue Cross and Blue Shield of Florida, are Independent Licensees of the Blue Cross and Blue Shield Association.

SMALL EMPLOYER APPLICATION AMENDMENT

I. Applicant Information

A. Group Name (from current application): _____ Group #: _____

B. Applicant hereby applies for an Amendment to the Group Policy that is currently being reviewed/issued by Blue Cross and Blue Shield of Florida, Inc. (BCBSF) and/or Health Options, Inc. (HOI). Upon acceptance of this amendment by BCBSF and/or HOI, it will become part of the Policy issued to the applicant named above.

C. The effective date of the following amendment(s) to the current Policy shall be: _____

II. Requested Amendment to the Current Policy

- ☐ Change: Group Name or Affiliate Name
- ☐ Change: Policy Effective Date
- ☐ Change: Waiting Period
- ☐ Change: Add New Employees on
- ☐ Change: Term Employees on
- ☐ Change: Employer Contribution
- ☐ Change: Health Plan (Product)
- ☐ Change: Other

COMPLETE ONLY THOSE SECTIONS RELEVANT TO THE REQUESTED AMENDMENT TO YOUR CURRENT POLICY.

III. Change: Group Name or Affiliate Name

New Group Name: _____

New Affiliate Name: _____

IV. Change: Policy Effective Date

The new effective date of this Policy shall be _____

V. Change: Waiting Period

New eligibile employees may be covered effective after ____ days of employment, so long as the eligible employee submits an application to BCBSF/HOI within 30 days of the date the individual first meets the applicable eligibility requirements. (For Standard and Basic products the waiting period cannot exceed 90 days).

VI. Change: Add New Employees on

Add New Eligible Employees on ☐ 1st day of billing cycle ☐ Date of hire

VII. Change: Term Employees on

Term Eligible Employees on: ☐ Last day of billing cycle ☐ Termination Date

VIII. Change: Employer Contribution

Employer Contribution: Employee: ____ % Dependents ____ %

IX. Change: Health Plan (Product)

☐ Single ☐ Blue Packages

Health Plan Summary Information *(complete one section for each plan selected)*

Health Plan Name _____

Rx Option *(indicate copayments):* _____

Deductible:

Per Person _____

Per Family _____

Rates: ☐ Composite ☐ Table (see attached rate sheet)

Coinsurance:

In-Network / Participating _____

Out-of-Network / Non-Participating _____

Office Visit Copay:

Family Phy. _____

All Other Providers _____

Employee ____ Employee/Spouse ____ Employee/Child(ren) ____ Family ____ Other ____

Health Plan Name

Rx Option *(indicate copayments):*

Deductible:

Per Person

Per Family

Rates: ☐ Composite ☐ Table (see attached rate sheet)

Coinsurance:

In-Network / Participating

Out-of-Network / Non-Participating

Office Visit Copay:

Family Phy.

All Other Providers

Employee Employee/Spouse Employee/Child(ren) Family Other

Health Plan Name

Rx Option *(indicate copayments):*

Deductible:

Per Person

Per Family

Rates: ☐ Composite ☐ Table (see attached rate sheet)

Coinsurance:

In-Network / Participating

Out-of-Network / Non-Participating

Office Visit Copay:

Family Phy.

All Other Providers

Employee Employee/Spouse Employee/Child(ren) Family Other

Health Plan Name

Rx Option *(indicate copayments):*

Deductible:

Per Person

Per Family

Rates: ☐ Composite ☐ Table (see attached rate sheet)

Coinsurance:

In-Network / Participating

Out-of-Network / Non-Participating

Office Visit Copay:

Family Phy.

All Other Providers

Employee Employee/Spouse Employee/Child(ren) Family Other

Health Plan Name

Rx Option *(indicate copayments):*

Deductible:

Per Person

Per Family

Rates: ☐ Composite ☐ Table (see attached rate sheet)

Coinsurance:

In-Network / Participating

Out-of-Network / Non-Participating

Office Visit Copay:

Family Phy.

All Other Providers

Employee Employee/Spouse Employee/Child(ren) Family Other

Health Plan Name

Rx Option *(indicate copayments):*

Deductible:

Per Person

Per Family

Rates: ☐ Composite ☐ Table (see attached rate sheet)

Coinsurance:

In-Network / Participating

Out-of-Network / Non-Participating

Office Visit Copay:

Family Phy.

All Other Providers

Employee Employee/Spouse Employee/Child(ren) Family Other

Health Plan Name

Rx Option *(indicate copayments):*

Deductible:

Per Person

Per Family

Rates: ☐ Composite ☐ Table (see attached rate sheet)

Coinsurance:

In-Network / Participating

Out-of-Network / Non-Participating

Office Visit Copay:

Family Phy.

All Other Providers

Employee Employee/Spouse Employee/Child(ren) Family Other

Health Plan Name

Rx Option *(indicate copayments):*

Deductible:

Per Person

Per Family

Rates: ☐ Composite ☐ Table (see attached rate sheet)

Coinsurance:

In-Network / Participating

Out-of-Network / Non-Participating

Office Visit Copay:

Family Phy.

All Other Providers

Employee Employee/Spouse Employee/Child(ren) Family Other

Health Savings Account (HSA) Banking Arrangement *(optional with HSA compatible health plans)*

Are you choosing BCBSF's integrated HSA banking arrangement ☐ Yes ☐ No *(if left blank, the response is assumed to be no.)*

If applicant chose the HSA Banking Arrangement, applicant agrees to obtain from each employee, enrolling in a high deductible health plan issued or administered by BCBSF and establishing in HSA in conjunction therewith, the employee's signed authorization (in a form acceptable to BCBSF) that authorizes BCBSF to disclose to BCBSF's preferred bank (or other bank selected by applicant) such information, including protected health information, of the employee as the bank may require to establish and maintain the employee's HSA, facilitate direct deposits to the employee's HSA, and comply with the terms of the bank's depository agreement. Applicant acknowledges and agrees that BCBSF does not provide banking services and that BCBSF is not responsible for the provision of HSA services. HSA services are provided by the bank of applicant's choice subject to the terms and conditions of such agreements, including fee, as the bank may require.

X. Change: Other

If applicant is applying for BlueSelect, applicant acknowledges that all eligible employees live, reside or work in the Service Area. Also, applicant acknowledges receipt of (1) a description of the exclusive providers; (2) a description of the exclusive provider provisions including coinsurance and deductible levels if providers other than exclusive providers are used; (3) a description of coverage for emergency and urgently needed care and other out-of-service area coverage; (4) a description of limitations on referrals to restricted exclusive providers and to other providers; and (5) a description of BCBSF's quality assurance program and grievance procedure. Applicant further acknowledges and understands the restrictions of the BlueSelect product.

If applicant is applying for Miami-Dade Blue, applicant acknowledges there is no participating provider network outside of Miami-Dade County, and that members will be responsible for all charges that exceed BCBSF's payment amount for services received from non-participating providers.

Upon acceptance for coverage this amendment will become a part of the Group Policy issued, along with the Small Employer Application. The applicant certifies the information contained in this amendment is true and complete and acknowledges that if a misrepresentation was made regarding eligibility, this coverage may be cancelled or rescinded. The applicant understands that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Issuance of the Policy by BCBSF and/or HOI will be deemed acceptance of this amendment.

Date Signature of Applicant Print/Type Name & Title

Date Blue Cross and Blue Shield of Florida, Inc. and/or Health Options, Inc. Signature of Agent

Agent License Identification Number