Health Care Account ("HCA") Plan
Benefit Program Application ("BPA")

Employer Group Number(s):

Section Number(s):

Employer Legal Name:

(Specify the employer or the employee trust applying for coverage. Names of subsidiary or affiliated companies to be covered must also be included. AN EMPLOYEE BENEFIT PLAN *MAY NOT* BE NAMED)

Employer Identification Number (EIN):

Address: Phone Number:

City: State: Zip:

Subsidiaries to be covered:

Affiliated Companies to be covered:

Administrative Contact: Title:

Phone Number: FAX: Email:

Plan Administrator: ERISA Plan Year:

Effective Date of Coverage: Anniversary Date:

SCHEDULE OF ELIGIBILITY

Eligible Person, the Effective Date of termination for a person who ceases to meet the definition of Eligible Person, the Limiting Age for covered Dependent children, the Eligibility Date for a person who becomes an Eligible Person after the Effective Date of the Employer's HCA Plan, HCA Plan enrollment options, and extension of benefits due to Temporary Layoff, Disability or Leave of Absence, shall be as specified under the Employer's HCA Plan.

IMPORTANT TAX NOTE: Health Reimbursement Arrangements ("HRAs") – referred to herein as Health Care Accounts ("HCAs") – have tax and legal ramifications. I.R.S. Regulations require Employers to comply with certain requirements, including those concerning participant eligibility, for HRAs (such as this HCA), particularly if HRA benefits are made available to self-employed individuals. In some circumstances HRA benefits might constitute income to such participants.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("BCBSTX") is not responsible for ensuring or verifying participant eligibility. Further, BCBSTX does not provide legal or tax advice, and nothing herein, nor in any materials incorporated into this document, should be construed as legal or tax advice. Any tax-related statements in the aforementioned materials may have been written in connection with the promotion or marketing of the transaction(s) or matter(s) addressed within this or accompanying materials and are not intended nor written to be used, and cannot be used nor relied on, for the purpose of avoiding tax penalties.

Employer should seek advice based on participants' particular circumstances from an independent tax advisor regarding the tax consequences of specific health insurance plans or products.

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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

Health Care Account (HCA)

☐ BlueEdge HCA℠ ☐ BlueEdge Wellness Rewards℠ HCA ☐ BlueEdge Limited Purpose HCA℠
☐ BlueEdge Vitality℠ HCA ☐ BlueEdge HCA Direct℠ (excluding BCBSTX)

HCA Account Structure (choose one)

☐ Employee Family	☐ Employee Employee + 1 Dependent Employee + 2 or more Dependents	☐ Employee Employee + Spouse Employee + Child(ren) Family

Employer HCA Contribution Amounts:
If funding is through incentives only, contribution amounts should remain blank. Please check the box for incentives below.

Employee	$_____	Family	$_____
Employee + Spouse	$_____	Employee + 1 Dependent	$_____
Employee + Child(ren)	$_____	Employee + 2 or more Dependents	$_____

BlueEdge HCA Direct Only: Self-Pay Corridor
Self-Pay Corridor is the difference between the plan deductible and the employer sponsored HCA.

Employee	$_____	Family	$_____
Employee + Spouse	$_____	Employee + 1 Dependent	$_____
Employee + Child(ren)	$_____	Employee + 2 or more Dependents	$_____

HCA Maximum-
HCA balance for contributions cannot exceed listed dollar amount, including incentives.

Employee	$_____	Family	$_____
Employee + Spouse	$_____	Employee + 1 Dependent	$_____
Employee + Child(ren)	$_____	Employee + 2 or more Dependents	$_____

HCA Roll Over Amount:
The amount of participant's balance to be carried forward to the next 12-month plan period. Rollover must be 100% if Rx expenses are integrated with a PBM and eligible for HCA reimbursement.

☐ 100% (recommended) ☐ 0% ☐ _____%

HCA Proration
For new subscribers and changes in coverage (e.g., from single to family)

☐ None ☐ Semi-Annual ☐ Quarterly ☐ Monthly

For subscribers terminating coverage and those who have a gap in coverage (e.g., rehires)

☐ Funds will be removed upon member cancellation based on Proration selected
☐ No funds should be removed upon cancellation (This option is available to custom HCA groups only.)

HCA Annual Contribution Frequency

The Employer has the option to stagger funding over the course of the year. If frequency is other than annual, it must match the Proration period selected above.

☐ Annual (recommended) ☐ Semi-Annual ☐ Quarterly ☐ Monthly

Incentives applied to HCA Yes ☐ No ☐

Additional Spending Account(s) paired with the product

Yes ☐ No ☐ If yes, please complete an Additional Health Care Account (HCA) chart for each account and indicate the order of payment.

1. ☐ 2. ☐ 3. ☐ 4. ☐

Do you have an existing HCA (HRA) that will require a credit of ending HCA balances? ☐ Yes ☐ No

Please indicate the date of the prior carrier credit: _____

HCA Account Yearly Claim Payment Options:
☐ Multiple- This is our recommended standard. Claims incurred in the current year may use current year contribution or rollover dollars from previous years. Current year contributions will not be available for the prior year's claims; only the rollover dollars are available for the prior year's claims.
☐ Single- All current funding and rollover dollars are available for claims incurred in any year.

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Additional Health Care Account (HCA)		
☐ BlueEdge HCA	☐ BlueEdge Wellness Rewards HCA	☐ BlueEdge Limited Purpose HCA
☐ BlueEdge Vitality HCA	☐ BlueEdge HCA Direct (excluding BCBSTX)	

HCA Account Structure (choose one)

☐	Employee Family	☐	Employee Employee + 1 Dependent Employee + 2 or more Dependents	☐	Employee Employee + Spouse Employee + Child(ren) Family

Employer HCA Contribution Amounts:

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Employee + Child(ren)	$_____	Employee + 2 or more Dependents	$_____

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Employee	$_____	Family	$_____
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Incentives applied to HCA Yes ☐ No ☐

Additional Spending Account(s) paired with the product

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☐ **BlueEdge Vitality HCA** ☐ **BlueEdge HCA Direct (excluding BCBSTX)**

HCA Account Structure (choose one)

☐ Employee
Family

☐ Employee
Employee + 1 Dependent
Employee + 2 or more Dependents

☐ Employee
Employee + Spouse
Employee + Child(ren)
Family

Employer HCA Contribution Amounts:
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By signing below, Employer acknowledges and agrees as follows:

- **Employer has reviewed and hereby accepts the benefits and other specifications, terms and conditions set out in the HCA Benefit Program Application and other applicable documentation (e.g., the Group Administration Document ("GAD"));**
- **Employer understands and agrees that the HCA is an Employer-sponsored benefit plan and that, even though the HCA is offered as a companion to the Employer's medical benefit plan, the HCA itself is a health and welfare benefit plan under ERISA and applicable federal or state employee benefit laws;**
- **Employer agrees that if at any time during the benefit year, a participant's HCA balance reflects a negative amount, BCBSTX will take the appropriate measures to recoup the over utilized HCA funds. If at the end of the benefit period, a participant's balance remains at a negative amount, full funding for the next year will be given; however, the available balance for the new benefit period will be reduced by the amount of the negative balance from the prior benefit period.**
- **Employer acknowledges and agrees that Employer is solely responsible for the creation, funding and maintenance of the HCA plan, including obligations under ERISA and applicable federal or state employee benefit laws and that BCBSTX as the HCA Administrator provides only HCA administrative services for the Employer-established HCA Plan;**
- **Employer agrees that this HCA Benefit Program Application and any exhibits, attachments, or amendments thereto constitute the entire agreement between the Employer and BCBSTX, with respect to the services to be provided to the Employer by BCBSTX, serving as the HCA Administrator.**

ADDITIONAL PROVISIONS:

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Sales Representative	Signature of Employer’s Authorized Purchaser
Date	Title
Address	Date
District Phone No.	
FAX No.	
Producer Representative	
Producer Firm	
Producer Address	
Producer Phone & FAX Numbers	
Producer email Address	
Tax I.D. No.	

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