

Benefit Program Application ("ASO BPA")

Application to Administrative Services Only (ASO) Group Accounts

administered by 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, hereinafter referred to as the "Claim
Administrator" or "BCBSTX"

Group Status: Renewing ASO Account

Employer Account Number (6-digits): 375298

Group Number(s): 375298 and 375299

Section Number(s): ALL

Legal Employer Name: The County of Galveston

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

ERISA Regulated Group Health Plan*: ☐ Yes ☒ No

Is your ERISA Plan Year* a period of 12 months beginning on the Effective Date of Coverage specified below? ☐ Yes

If not, please specify your ERISA Plan Year*: Beginning Date ___/___/___ End Date ___/___/___ (month/day/year)

ERISA Plan Administrator*: _____

Plan Administrator's Address: _____

If you maintain that ERISA is not applicable to your group health plan, give legal reason for exemption:

Select from drop down ; if applicable, specify other: _____

Is your Non-ERISA Plan Year* a period of 12 months beginning on the Anniversary Date specified below? ☐ Yes

If not, please specify your Non-ERISA Plan Year*: Beginning Date ___/___/___ End Date ___/___/___ (month/day/year)

For more information regarding ERISA, contact your Legal Advisor.

*All as defined by ERISA and/or other applicable law/regulations

Effective Date of Coverage: (Month/day/Year) 01 / 01 / 2026

Anniversary Date: (Month/Day/Year) 01 / 01 / 2027

Retiree-Only Plan(s) Identification:

For more information regarding Retiree-only plans, contact your Legal Advisor.

Do you have one or more Retiree-only plan(s)? ☒ Yes ☐ No

If yes, please provide Benefit Agreement number, or group and section numbers of the Retiree-only plan(s):

R100, R101, R102, R103, R200, R201, R202, R203, R300, R301, R302, and R303

Account Information

☒ NO CHANGES

☐ SEE ADDITIONAL PROVISIONS

Standard Industry Code (SIC): 9211

Employer Identification Number (EIN): 746000908

Address: 722 Moody Avenue, 3rd Floor

City: Galveston

State: TX

ZIP: 77550

Administrative Contact: Rebecca Gilliam

Title: Director of Human Resources

Email Address:

Rebecca.Gilliam@galvestoncountytexas.gov

Phone Number: 409-770-5346

Fax Number: 409-766-4599

☐ Mailing address is different from primary address

Mailing Address: _____

City: _____

State: _____

ZIP: _____

Mailing Contact: _____

Title: _____

Email Address: _____

Phone Number: _____

Fax Number: _____

☐ Billing address is different from primary address

Billing Address: _____

City: _____

State: _____

ZIP: _____

Proprietary and Confidential Information of Claim Administrator

Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator.

Billing Contact: _____

Title: _____

Email Address: _____

Phone Number: _____

Fax Number: _____

Wholly Owned Subsidiaries to be covered: _____

Affiliated Companies to be covered: _____

Employer Identification Number (EIN): _____

(Affiliated Companies must be required or permitted to be aggregated per IRS Guidelines., Employer hereby confirms that Employer, Subsidiaries and Affiliates are treated as a single employer under Internal Revenue Code Section 414(b), or (c), or (m) or (o), or under applicable law.)

Subsidiary / Affiliate Address: _____

City: _____

State: _____

ZIP: _____

Subsidiary / Affiliate Contact: _____

Title: _____

Email Address: _____

Phone Number: _____

Fax Number: _____

Blue Access for EmployersSM ("BAESM") Contact: _____

Title: _____

(The BAE Contact is the Employee authorized by the Employer to access and maintain the Employer's account in BAE.)

Email Address: _____

Phone Number: _____

Fax Number: _____

Producer of Record Information☒ **NO CHANGES**☐ **SEE ADDITIONAL PROVISIONS**

Effective: 01/01/2024

If applicable, the below-named producer(s) or agency(ies) is/are recognized as the Employer's Producer of Record (POR) to act as a representative in negotiations with and to receive commissions from BCBSTX, or Claim Administrator's corporate subsidiaries, as applicable, for procuring Claim Administrator's claims administration services for Employer's employee benefit program(s). This statement rescinds any and all previous POR appointments for the Employer. The POR is authorized to perform membership transactions on behalf of the Employer. This appointment will remain in effect until withdrawn or superseded in writing by Employer.

Producer/Consultant Compensation:

The Employer acknowledges that if its POR acts on its behalf for purposes of purchasing services in connection with the Employer's Plan under the Administrative Services Agreement to which this ASO BPA is attached, the Claim Administrator may pay the Employer's POR a commission and/or other compensation in connection with such services under the Administrative Services Agreement. If the Employer desires additional information regarding commissions and/or other compensation paid to the POR by the Claim Administrator in connection with services under the Administrative Services Agreement, the Employer should contact its POR.

Producer or Agency to whom commissions are to be paid*: Alliant Insurance ServicesTexas Producer #: 010042327NPN: 0000784013Address: 3600 N. Capital of Texas Hwy, B-100City: AustinState: TXZIP: 78746Phone: 281-773-8954Fax: N/AEmail: Nick.Long@alliant.comIs Producer/Agency appointed with BCBSTX in Texas? ☒ Yes ☐ No General Agent? ☐ Yes ☒ NoAffiliated with General Agent? ☐ Yes ☒ NoIs there a secondary Producer or Agency to whom commissions are to be paid? ☐ Yes ☒ No**If Yes**, Producer or Agency to whom commissions are to be paid*: _____**Texas Producer #: (nine digits)

NPN: _____

Address: _____

City: _____

State: _____

ZIP: _____

Phone: _____

Fax: _____

Email: _____

Is Producer/Agency appointed with BCBSTX in Texas? ☐ Yes ☐ No General Agent? ☐ Yes ☐ No

Commissions:

☒ PCPM \$0.00 Does a Monthly Cap Apply ☐ Yes ☒ No \$_____ (If cap is annual, divide by twelve)☐ Flat \$_____ Does a Monthly Cap Apply ☐ Yes ☐ No \$_____ (If cap is annual, divide by twelve)**Proprietary and Confidential Information of Claim Administrator**

Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator.

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☐ Percentage of Stop Loss: _____%

ADDITIONAL COMMISSIONS: _____

Affiliated with General Agent? ☐ Yes ☐ No

If commission split**, designate percentage for each producer/agency (total commissions paid must equal 100%):

Producer /Agency 1: 100%

Producer /Agency 2: _____%

Multiple Location Agency(ies): If servicing agency is not listed above as primary or secondary Producer or Agency above, specify location below:

* 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 BCBSTX in Texas.

Schedule of Eligibility

☒ NO CHANGES

☐ SEE ADDITIONAL PROVISIONS

Employer has made the following eligibility decisions:

1. Eligible Person means:

- ☒ A full-time employee of the Employer.
- ☐ A full-time employee of the Employer who is a member of: _____ (name of union)
- ☐ A part-time employee of the Employer.
- ☒ A retiree of the Employer. Define criteria: _____
- ☒ Other: A Part - Time Benefit Eligible Employee

Are any classes of employees to be excluded from coverage? ☐ Yes ☒ No

If yes, please identify the classes and describe the exclusion: _____

2. Employee definition:

Full-Time Employee means:

- ☒ A person who is regularly scheduled to work a minimum of _____ hours per week and who is on the permanent payroll of the Employer.
- ☐ Other: _____

Part-Time Employee means:

- ☒ A person who is regularly scheduled to work a minimum of _____ hours per week and who is on the permanent payroll of the Employer.
- ☒ Other: Part Time Benefit Eligible Employees

3. The Effective Date of termination for a person who ceases to meet the definition of Eligible Person:

- ☐ The date such person ceases to meet the definition of Eligible Person.
- ☒ The last day of the calendar month in which such person ceases to meet the definition of an Eligible Person.
- ☐ Other: _____

4. Select an effective date rule for a person who becomes an Eligible Person after the Effective Date of the Employer's health care plan (the effective date must not be later than the 91st calendar day after the date that a newly eligible person becomes eligible for coverage, unless otherwise permitted by applicable law).

- ☐ The date of employment.
- ☐ The _____ day of employment.
- ☐ The _____ day of the month following _____ month(s) of employment.
- ☒ The 1st day of the month following 30 days of employment.
- ☐ The _____ day of the month following the date of employment.
- ☐ Other: _____

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

Are there multiple new hire waiting periods? ☐ Yes ☒ No

If yes, please attach eligibility and contribution details for each section.

5. Domestic partners covered: ☐ Yes ☒ No

If yes, a domestic partner is eligible to enroll for coverage.

If yes, are domestic partners eligible for continuation of coverage? ☐ Yes ☐ No

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If yes, are dependents of domestic partners eligible to enroll for coverage? ☐ Yes ☐ No

If yes, are dependents of domestic partners eligible for continuation of coverage? ☐ Yes ☐ No

The Employer is responsible for providing notice of possible tax implications to those Covered Employees with coverage for domestic partners and/or dependents of domestic partners.

6. **Are unmarried grandchildren eligible for coverage?** ☐ Yes (answer the question below) ☒ No
Must the grandchild be dependent on the employee for federal income tax purposes at the time application is made?
☒ Yes ☐ No

7. **Limiting Age for covered children:** Twenty-six (26) years, 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. Other:

8. **Termination of coverage upon reaching the Limiting Age:**

- ☐ The last day of coverage is the day prior to the birthday.
☒ The last day of coverage is the last day of the month in which the limiting age is reached.
☐ The last day of coverage is the last day of the billing month.
☐ The last day of coverage is the last day of the year (12/31) in which the limiting age is reached.
☐ The last day of coverage is the day prior to the Employer's Anniversary Date.

Automatically cancel dependents when they reach the day their coverage terminates? ☐ Yes ☒ No

**Automatically canceling dependents is not recommended for accounts with automated eligibility*

Will coverage for a child who is medically certified as disabled and dependent on the employee terminate upon reaching the Limiting Age even if the child continues to be both disabled and dependent on the employee?

☐ Yes ☒ No

However, such coverage shall be extended in accordance with any applicable federal or state law and the Disabled Dependent provisions of this BPA. The Employer will notify BCBSTX of any instance where the continuation of disabled dependent coverage is required.

9. **Disabled dependent:** A disabled dependent means a dependent child who is medically certified as disabled and dependent upon the Employee or his/her spouse. A child is a disabled child when the child is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months, per Internal Revenue Code Section 22(e)(3).

To administer medical certification of disabled dependents, you may select option (a) Standard Rules or (b) Custom Rules. BCBSTX will administer its standard process for administration of disabled dependent coverage if (a) below is selected by Employer, or at the Employer's direction memorialized below, BCBSTX will follow a customized process if Employer selects (b). 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 is eligible to **continue** coverage beyond the limiting age, provided the disability began before the child attained the age of 26. A disabled dependent is eligible to **be added to** coverage beyond the limiting age, provided the disability began before the child attained the age of 26, and proof of coverage as a disabled dependent is provided. Administration of certification review is administered by BCBSTX; a disabled dependent certification form must be submitted to BCBSTX.

- (b) ☒ Disabled dependent Administration will follow **Custom Rules**. Please make the following sections:

Age: Please select one option regarding age of when the disability began.

- ☒ The disability must have begun before the child attained the age of 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 option regarding the administration of certification review.

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- ☒ Certification review is administered by BCBSTX; a disabled dependent certification form must be submitted to BCBSTX.
- ☐ Certification review is administered by the Employer; there are no disabled dependent certification form requirements.

If certification review is administered by BCBSTX, please select one option regarding forms:

- ☒ Utilize BCBSTX's disabled dependent certification forms.
- ☐ Utilize custom/other disabled dependent certification forms.

If Certification Review is administered by BCBSTX, please select allowed or not allowed below:

A disabled dependent approved certification from a prior insurance carrier is ☒ allowed ☐ not allowed.

A disabled dependent approved certification from a prior BCBS policy is ☒ allowed ☐ not allowed.

10. Will extension of benefits due to temporary layoff, disability or leave of absence apply?

- ☐ Yes (specify number of days below) ☒ No

Temporary Layoff: days Disability: days Leave of Absence: days

However, benefits shall be extended for the duration of an Eligible Person's leave in accordance with any applicable federal or state law. The Employer will notify BCBSTX in any instance where an extension of benefits is to be provided due to a temporary layoff, disability, or leave of absence.

11. Enrollment:

Special Enrollment: An Eligible Person may apply for coverage, family coverage or add dependents within thirty-one (31) days of a Special Enrollment qualifying event if he/she did not previously apply prior to his/her Eligibility Date or when otherwise eligible to do so. Such person's Coverage Date, family Coverage Date, and/or dependent's Coverage Date will be the effective date of the qualifying event or, in the event of Special Enrollment due to marriage or termination of previous coverage, then no later than the first day of the Plan Month following the date of receipt of the person's application of coverage.

An Eligible Person may apply for coverage within sixty (60) days of a Special Enrollment qualifying event in the case either of a loss of coverage under Medicaid or a state Children's Health Insurance program, or eligibility for group coverage where the Eligible Person is deemed qualified for group coverage assistance under a state Medicaid or CHIP premium assistance program.

Open Enrollment: An Eligible Person may apply for coverage, family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when otherwise eligible to do so, during the Employer's annual Open Enrollment Period. Such person's Coverage Date, family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by the Claim Administrator and the Employer. Such date shall be subsequent to the Open Enrollment Period. Specify Open Enrollment Period: _____

Late Enrollment: An Eligible Person may apply for coverage, family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when otherwise eligible to do so. Such person's Coverage Date, family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by the Claim Administrator and the Employer.

Select one of the provisions below:

- ☒ Open Enrollment – Late applicants may only apply during Open Enrollment.
- ☐ Late Entrant – Late applicants may apply at any time – coverage effective date is determined by the receipt date and allowed rules governing off-cycle enrollments.

12. * Does COBRA Auto Cancel apply? ☐ Yes ☒ No

Member's COBRA/Continuation of coverage will be automatically cancelled at the end of the member's eligibility period.

**Not recommended for accounts with automated eligibility*

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CURRENT ELIGIBILITY INFORMATION

☒ **NO CHANGES** ☐ **Current number of Employees enrolled** _____ ☐ **SEE ADDITIONAL PROVISIONS**

Current Employee Eligibility Information only applies to new accounts. If your account is renewing, please just indicate the current number of enrolled employees (above).

Total number of Employees/Subscribers:

1. on payroll _____
2. total number of employees presently eligible for coverage _____
3. on COBRA continuation coverage _____
4. with retiree coverage (if applicable) _____
5. who work part-time _____
6. serving the new hire probationary period _____
7. declining because of other group coverage (e.g., other commercial group coverage, Medicare, Medicaid, TRICARE/Champus) _____
8. declining coverage (not covered elsewhere) _____

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Lines of Business (Check all applicable services)☐ **NO CHANGES**☐ **See Additional Provisions****Medical Plan Services:**☒ **PPO:** Plan Name: PPO Base Plan (\$2250 Ded)Plan Name: PPO Buy Up Plan (\$1500 Ded)Plan Name: HSA Plan (\$3400 Ded Embedded)

Plan Name: _____

Plan Name: _____

☐ **HMO:** Plan Name: _____☐ Prescription Drug Option:
Select From List☐ No Prescription Drug Option☐ Blue High Performance
NetworkSM (BlueHPNSM)☐ **EPO:** Plan Name: _____☐ **POS:** Plan Name: _____**Additional Services:**☒ Wellbeing Management☐ Wellness Incentives☐ Health Advocacy Solutions☐ Mercer Health Advantage☐ Custom Care Management Unit☐ Blue DirectionsSM (Private Exchange)
(If selected, the Blue Directions
Addendum must be attached and made a
part of the parties' Administrative
Services Agreement.)☐ In-Hospital Indemnity (IHI)☐ Limited Fiduciary Services for
Claims and Appeals☐ Other Select Product☐ Other Select Product☒ Other Catapult☐ Other**Consumer Driven Health Plan**☐ BlueEdgeSM HCA, (if selected, complete separate HCA Benefit Program
Application)☒ BlueEdgeSM HSA, (Integrated Vendor: Select Vendor)* If
HealthEquity, Inc. is selected, BCBSTX to send HSA enrollment to
HealthEquity, Inc. ☐ Yes ☐ No Non-Integrated Vendor:☐ FSA (Integrated Vendor: Select Vendor)* Non-Integrated Vendor:☐ HRA (Integrated Vendor: Select Vendor)* Non-Integrated Vendor:**Traditional Coverage:**☐ Out-of-Area (Indemnity)☐ Benefit Offering**Prescription Drugs:**☒ (If selected, the PBM Fee Schedule Addendum must be attached and is
part of this BPA.)**Pharmacy Network (Select one):**☒ Traditional Select Network☐ Advantage Network☐ Preferred Network☐ Elite Network☐ Network on PBM Fee Schedule Addendum☐ Other (please specify):

Drug List: Balanced Drug List

Other (please specify):

PPO/HSA Preventive Drug List:

Please specify: HSA

Other Rx programs:

Please specify: Select Program

Ancillary Services:☐ Vision Insurance (if selected, complete a separate application)☒ Stop Loss Coverage (If selected, complete separate Application and
Policy Schedule for Stop Loss Coverage)☐ Life, Disability, Specified Disease, Accident or Hospital Indemnity
Insurance (If selected, complete a separate application for those coverages)☐ COBRA Administrative Services (Please provide name of entity
administering COBRA: _____)☐ Dental Plan Services

Plan Name: _____ Select From List

*An HSA must be paired with a qualified high deductible health plan (HDHP) and follow strict requirements set forth by the Internal Revenue Service (IRS). Employer Groups should seek advice from their independent tax advisor, legal counsel, or other professional counselor, to ensure their proposed benefit strategy with respect to HSAs, FSAs, HRAs, or other benefit arrangements does not conflict with current IRS requirements.

Mercer Health Advantage is offered by Mercer, an independent company, and is administered by Blue Cross and Blue Shield of Texas.

Custom Care Management Unit is offered by WTW, an independent company, and is administered by Blue Cross and Blue Shield of Texas.

Medical and Dental benefits and services are administered by 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.

Life, Disability, Specified Disease, Accident, Hospital Indemnity and Vision Insurance is underwritten by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Blue Cross and Blue Shield of Texas is the trade name of Dearborn Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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FEE SCHEDULE

Employer shall pay amounts Claim Administrator bills Employer for benefit claims Claim Administrator processes on Employer's behalf as well as administrative fees as set forth in this Fee Schedule.

Payment Specifications		☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS	
Employer Payment Method: ☐ Online Bill Pay ☒ Electronic ☐ Auto Debit ☐ Check			
Employer Payment Period: ☒ Weekly (cannot be selected if Check is selected as payment method above) ☐ Semi Monthly (cannot be selected if Check is selected as payment method above) ☐ Monthly			
Run-Off Period: Employer Payments are to be made for <u>12</u> months following the end of the Fee Schedule Period. <i>Standard is twelve (12) months.</i>			
Fee Schedule Period: To begin on Effective Date of Coverage and continue for 12 months. If other than 12 months, please specify: months.			
Administrative Per Employee per Month (PEPM) Charges		☐ NO CHANGES ☒ SEE ADDITIONAL PROVISIONS	
	2026		
Administrative Fee	\$44.23	\$ _____	\$ _____
Dental	\$ _____	\$ _____	\$ _____
Claims Fiduciary	\$1.00	\$ _____	\$ _____
Advanced Payment Review	25%	%	%
	\$ _____	\$ _____	\$ _____
*Medical Drug Rebate Credit	\$(2.50)	\$(_____)	\$(_____)
*Rebate Credit for the Prescription Drug Program	\$(107.45)	\$(_____)	\$(_____)
Telehealth (Virtual Visits)	\$0.52	\$ _____	\$ _____
Wellbeing Management	\$5.85	\$ _____	\$ _____
Health Advocacy Solutions	\$ _____	\$ _____	\$ _____
Commissions: _____	\$ _____	\$ _____	\$ _____
Commissions: _____	\$ _____	\$ _____	\$ _____
Commissions: _____	\$ _____	\$ _____	\$ _____
Other: Other Services	\$3.52	\$ _____	\$ _____
List Service: <u>Communication Allowance</u>			
Other: Select Service Category	\$ _____	\$ _____	\$ _____
List Service: _____			
Other: Select Service Category	\$ _____	\$ _____	\$ _____
List Service: _____			
Miscellaneous: _____	\$ _____	\$ _____	\$ _____
Miscellaneous: _____	\$ _____	\$ _____	\$ _____
Total	\$(55.83)	\$ _____	\$ _____

*The Rebate Credit is a per Covered Employee per month credit applied to the monthly billing statement. The Employer and Claim Administrator have agreed to the Rebate Credit and Employer agrees that it and its group health plan have no

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right to, or legal interest in, any portion of the rebates, either under the pharmacy benefit or the medical benefit, actually provided by the Pharmacy Benefit Manager ("PBM") or a pharmaceutical manufacturer to Claim Administrator and consents to Claim Administrator's retention of all such rebates. The Rebate Credit will be provided from Claim Administrator's own assets and may or may not equal the entire amount of rebates actually provided to Claim Administrator by the PBM or expected to be provided. Rebate Credits shall not continue after termination of the Prescription Drug Program. Employer agrees that any Rebate Credit provision in the governing Administrative Services Agreement to the contrary is hereby superseded.

Administrative Line Item Charges	Frequency	Amount
☐ SEE ADDITIONAL PROVISIONS		
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	\$ _____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	\$ _____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	\$ _____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	\$ _____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	\$ _____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	\$ _____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	_____ %
Total:		\$ _____

Other Service and/or Program Fee(s)	☒ NO CHANGES	☐ SEE ADDITIONAL PROVISIONS
NSA Fees In connection with the claims, items, and services that are subject to the No Surprises Act ("NSA") and disputed by a Provider, Employer agrees to pay Claim Administrator the following fees: - Fifty dollars (\$50) for each claim that is the subject of informal negotiation with a Provider (this fee will be charged in the event the Provider, in its sole discretion, determines that it will not accept the initial payment amount); and - An additional seventy-five dollars (\$75) per claim for each independent dispute resolution process ("IDR") where Claim Administrator represents Plan (this fee will be charged in the event the Provider, in its sole discretion, determines that it will initiate IDR after the informal negotiation period); and All costs imposed by the IDR entity or any state, federal or local government entity in connection with an IDR.		
Not applicable to Grandfathered Plans External Review Coordination: ☐ Yes ☐ No If yes, coordination fee: \$700 for each external review requested by a Covered Person that the Claim Administrator coordinates for the Employer in relation to the Employer's Plan. Employer elects for external reviews to be performed under the Affordable Care Act external review process. If no, provide name and address of administrator(s) of external review coordination and indicate if administering medical claims and/or pharmacy claims: Administrator: Medical claims: ☐ Pharmacy claims: ☐ Name: _____ Mailing Address: _____ Administrator: Medical claims: ☐ Pharmacy claims: ☐ Name: _____ Mailing Address: _____		

Advanced Payment Review (APR): ☒ Yes ☐ No

APR is a suite of payment integrity offerings. Refer to the Matrix. If Employer elects APR, indicate APR Savings Program or PEPM below:

☒ APR Savings Program

☐ PEPM

For APR capabilities other than Reimbursement Services: If Employer elects APR Savings Program, Claim Administrator will invoice the percentage indicated in the Fee Schedule of any savings amounts identified by Claim Administrator or third-party.

Reimbursement Services: ☒ Yes ☐ No If yes, Claim Administrator will retain twenty-five percent (25%) of any recovered amounts made on third-party liability claims other than recovery amounts received as a result of or associated with any Workers' Compensation Law.

FlexAccess™: ☐ Yes ☒ No

As part of its plan design, Employer has directed Claim Administrator to administer claims, copay and coinsurance requirements for Covered Persons enrolled in the FlexAccess program, including (i) adjusting Covered Persons' copayment amounts to the amount of the manufacturer copay assistance, (ii) applying such manufacturer assistance to reduce Covered Persons' out of pocket costs, and (iii) not applying the manufacturer assistance to Covered Persons' deductibles and/or out of pocket maximum accumulators. Employer agrees that FlexAccess is a plan design decision of Employer and is consistent with Employer's plan design and supported by plan documents. Employer further agrees it is solely responsible for, and will hold Claim Administrator harmless from, the legal and regulatory compliance of the Plan and its plan design, to the extent permitted by law.

Claim Administrator will assess a program fee equal to 20% of the total shared savings. Total shared savings is calculated as the difference between Employer responsibility without the FlexAccess Program and Employer responsibility with the FlexAccess Program. The Employer responsibility without the FlexAccess Program is the cost of the drug minus the Covered Person's cost share if the Covered Person was not enrolled in the program. The Employer responsibility with the FlexAccess Program is cost of the drug minus: (1) the manufacturer copay assistance dollars that are allocated to the cost of the drug and (2) the cost share for the Covered Persons enrolled in the program.

FLEXACCESS™ QUALIFIED HDHP: ☐ Yes ☒ No

As part of its plan design, Employer has directed Claim Administrator to administer claims, copay and co-insurance requirements for Covered Persons enrolled in FlexAccess Qualified HDHP, including applying such manufacturer copay assistance to reduce Covered Persons' out of pocket costs, and not applying the manufacturer assistance to Covered Persons' deductibles and/or out of pocket maximum accumulators. Employer agrees that FlexAccess Qualified HDHP is a plan design decision of Employer and is consistent with its plan design and supported by the Employer's plan documents. Employer further agrees it is solely responsible for, and will hold Claim Administrator harmless from, the legal and regulatory compliance of the Plan and its plan design, to the extent permitted by law.

Claim Administrator will assess a fee equal to 20% of program savings for administrative fees. Program savings (shared savings) will be calculated based on the manufacturer copay assistance dollars that are allocated to the cost of the drug minus the Covered Persons' estimated cost share (copay or coinsurance) that would have been paid if they were not enrolled in the program.

The difference between Employer Responsibility for claims utilizing FlexAccess Qualified HDHP and not utilizing FlexAccess Qualified HDHP includes as follows:

WITH FLEXACCESS QUALIFIED HDHP: Cost of drug – amount manufacturer copay assistance used – Covered Persons' out-of-pocket cost (if any) up to Deductible... Copay assistance reversed from deductible. Plan pays no portion.

WITHOUT FLEXACCESS QUALIFIED HDHP: Cost of drug – Covered Persons' out-of-pocket cost - Non-FlexAccess Qualified HDHP coupon... Copay assistance applied to Deductible. Plan may pay portion of claim after deductible met

Third-Party Law Firms Provisions (other than Reimbursement Services): Employer will pay no more than 35% of any recovered amount made by Claim Administrator's third-party law firm or up to 35% of any recovered amount will be deducted from the amount distributed according to established allocation processes.

Alternative Compensation Arrangements: Employer acknowledges and agrees that Claim Administrator has Alternative Compensation Arrangements with contracted providers, including but not limited to Accountable Care Organizations and other Value Based Programs. Further information concerning Employer's payment for covered services under such Arrangements is described in the Administrative Services Agreement between the Claim Administrator and the Employer.

Proprietary and Confidential Information of Claim Administrator

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Virtual Visits Program: ☒ Yes ☐ No If yes, Covered Persons would be able to obtain certain Covered Services remotely via interactive video and/or interactive audio/video (where available) capability from Virtual Visits powered by MDLIVE.

MDLIVE® is a separate company that operates and administers Virtual Visits for persons with coverage through Blue Cross and Blue Shield of Texas. MDLIVE is solely responsible for its operations and for those of its contracted providers. MDLIVE® and the MDLIVE logo are registered trademarks of MDLIVE, Inc., and may not be used without permission.

Termination Administrative Charges

As applies to the Run-Off Period indicated in the Payment Specifications section above:

The Termination Administrative Charge applicable to the Run-Off Period shall be equal to the sum of the amounts obtained by multiplying the total number of Covered Employees by category (*per Covered Employee per individual or family composite*) during the three (3) months immediately preceding the date of termination by the appropriate factors shown below. In the event of a partial termination, the Termination Administrative Charge shall be the sum of the amount obtained by multiplying three (3) times the total number of terminated Covered Employees by the appropriate factors shown below.

Service	2026			
Medical Run-off Administration Charge	\$12.60	\$ _____	\$ _____	\$ _____
Dental Run-off Administration Charge	\$ _____	\$ _____	\$ _____	\$ _____
Miscellaneous	\$ _____	\$ _____	\$ _____	\$ _____
Miscellaneous	\$ _____	\$ _____	\$ _____	\$ _____
Total:	\$12.60	\$ _____	\$ _____	\$ _____

Other Provisions

☒ **NO CHANGES** ☐ **SEE ADDITIONAL PROVISIONS**

1. Summary of Benefits & Coverage:

- a. Will Claim Administrator create Summary of Benefits and Coverage (SBC)?
 - ☒ Yes. (Please answer question b. The SBC Addendum is attached.)
 - ☐ No. (If No, then skip question b and refer to the Administrative Services Agreement for further information.)
- b. Will Claim Administrator distribute the (SBC) to Covered Persons?
 - ☒ No. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Administrative Services Agreement) and provide SBC to Employer in electronic format. Employer will then distribute SBC to Covered Persons (or hire a third party to distribute) as required by law.
 - ☐ Yes. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Administrative Services Agreement) and distribute SBC to Covered Persons via regular hardcopy mail or electronically. Distribution Fee for hardcopy mail is one dollar fifty cents (\$1.50) per package.

2. Massachusetts Health Care Reform Act:

Does the Employer direct Claim Administrator to provide written statements of creditable coverage to its Covered Employees who reside, or have enrolled dependents who reside, in Massachusetts and file electronic reports to the Massachusetts Department of Revenue in a manner consistent with the requirements under the Massachusetts Health Care Reform Act? ☒ Yes ☐ No

If no: The Employer acknowledges ☐ it will provide written statements and electronic reporting to the Massachusetts Department of Revenue if required by the Massachusetts Health Care Reform Act or ☐ that it does not believe it is subject to the notification and reporting requirements of the Massachusetts Health Care Reform Act.

Please note Employer will be responsible for conducting or otherwise performing creditable coverage eligibility testing. By electing Claim Administrator to disseminate the above written statements, Employer is representing that any such coverage qualifies as creditable coverage under the applicable Massachusetts Health Care Reform Act requirements.

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3. **Alternative Care Management Program** (applicable to the purchased medical management program):

☐ Yes ☒ No

The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons for Utilization Management, Case Management, including but not limited to Behavioral Health, and other health care management programs.

4. **Prior Authorization** (applicable to the purchased medical management program): Employer acknowledges and agrees to utilize Claim Administrator's standard list of services and supplies for which Prior Authorization (also called pre-notification or preauthorization) is required.

5. **Essential Health Benefits ("EHB") Election:**

Employer elects EHBs based on the following:

1. ☒ EHBs based on a Claim Administrator state benchmark:
☐ Illinois ☐ Montana ☐ New Mexico ☐ Oklahoma ☒ Texas
2. ☐ EHBs based on benchmark of a state other than IL, MT, NM, OK and TX
If so, indicate the state's benchmark that Employer elects: ____
3. ☐ Other EHB, as determined by Employer

In the absence of an affirmative selection by Employer of its EHBs, then Employer is deemed to have elected the EHBs based on the Texas benchmark plan.

6. **Employer contribution:**

Employer Contribution – Medical	Employer Contribution – Dental
____ % of Employee's premium, or \$ ____	____ % of Employee's premium, or \$ ____
____ % of Dependent's premium, or \$ ____	____ % of Dependent's premium, or \$ ____

Comments: ____

7. This ASO BPA is binding on both parties and is incorporated into and made a part of the Administrative Services Agreement between the parties with both such documents to be referred to collectively as the "Administrative Services Agreement" unless specified otherwise.

8. **Independent Dispute Resolution Process:**

Employer authorizes and directs Claim Administrator to offer an amount not to exceed the greater of the Qualifying Payment Amount (QPA) or the amount allowed on the initial notice of payment or denial of a claim on behalf of the Employer during negotiations under the federal IDR process.

Additional Provisions:

The Account The County of Galveston TX375298 is renewing 01/01/2026 with the following benefits:

Account #375298

Cobra Vendor: Wex

AEP Vendor: WorkDay

Medical Coverage:

Group #375298 BA0001 PPO Base Plan (\$2250 Ded) : No Changes

ID Cards - Maintenance ONLY

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Group #375298 BA0002 PPO Buy Up Plan (\$1500 Ded) :

- Increasing Specialty Copay to \$50.00

ID Cards - Full Issuance - Copay Changes

Group #375299 BA0003 HSA Plan (\$3400 / \$6800 Ded, Embedded effective 01/01/2026) - Cost Share Changes due to IRS 2026 Guidelines - Increasing Deductible ONLY

ID Cards - Full Issuance - Cost Share Changes

HSA Vendor: Wex

•Credits: The County will be receiving one credit:

- BCBSTX will provide a one-time transition credit of \$50,000 for the twelve-month period beginning on the Contract Effective Date, to be used to cover costs and expenses associated with transitioning medical, prescription, stop loss, ancillary health or other coverage to BCBSTX and/or costs and expenses associated with transitioning to a new product design with BCBS[XX]. [For ERISA plans: Employer is accepting the transition credit on behalf of the ERISA plan. Employer hereby certifies that it will only use it for purposes consistent with the administration of the plan.] If Employer cancels before expiration of the policy period, Employer will be responsible for refunding to BCBSTX the full amount of the transition credit.

Alliant allowance: This was already in place last year and is included with the renewal for 1/1/2025 but I did want to include the below so everyone's aware:

-Alliant will be receiving a \$3.85 PEPM allowance that is built into the admin fee. This amount will get sent to the Alliant team at the end of the Calendar year

WBM: Enable, include Catapult, Livongo, Omada and Wondr

Account Confirmation forms sent 10/01 for ALL 3 vendors

RX Network: Traditional Select

RX Drug List: Balanced Drug List

RX Cohort: E Custom

RX Benefit Change : The County is Adding the KeepWell (Vida) Program for Obesity management. (Cathy Walsh has been notified and the KeepWell team is notified as well).

"Effective 01/01/2026, group is adding KeepWell Vida to their Pharmacy plan and

electing the Clinical Obesity management Program. Group opts for the Lock In Network.

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Coverage Code: KPVD, Descriptor Code(s): VDMN"

New coverage and descriptor codes have been added to BlueSTAR and are reflected on ABS/Matrices/PDP.

COVERAGE Vida: KPVD

DESCRIPTOR Preventive Care: VDCA

DESCRIPTOR Clinical Obesity Management: VDMN

DESCRIPTOR Clinical Obesity Management Plus: VDPL.

Stoploss Deductible: \$325,000

Broker: Alliant

Broker Contact: Emily.Fertitta@alliant (main contact)

Group Contact: Rebecca.Gilliam@galvestoncounty.gov

Account Structure: No Changes

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Signature

Daniel Eibel

Sales Representative

District

Phone & FAX Numbers

Producer Representative

Producer Firm

Producer Address

Producer Phone & FAX Numbers

Producer Email Address

Tax I.D. No.



Signature of Authorized Purchaser

Mark Henry

Print Name

County Judge

Title

November 24, 2025

Date

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Signature

Daniel Eibel

Sales Representative

District

Phone & FAX Numbers

Producer Representative

Producer Firm

Producer Address

Producer Phone & FAX Numbers

Producer Email Address

Tax I.D. No.

Signature of Authorized Purchaser

Print Name

Title

Date

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PROXY

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), 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 either revoked 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.

From time to time, 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.

☐ Intentionally left blank by the Employer

Group No.:

By:

Print Signer's Name Here



Signature and Title

Group Name: _____

Address: _____

City: _____

State: _____

ZIP: _____

Dated this _____

day of _____

Month

Year

Proprietary and Confidential Information of Claim Administrator

Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator.