PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

3800 Centerpoint Drive, Suite 940
Anchorage, AK 99503-5825

Fully Insured Large Group Master Application

Application is made to Premera Blue Cross Blue Shield of Alaska (hereafter referred to as "Premera", "we," "us," or "our") for a new Health Care Contract, the provisions of which shall be made available to all eligible classes of employees.

Your group cannot be enrolled prior to our receipt date of this completed and signed application.

A. Purpose

❍ New group. Complete this application and submit it with enrollment forms prior to the effective date of coverage.
❍ Other_____

Start date	Annual contract renewal month
From:_____ To:_____	

B. Group information

1.	Legal name:				
	Common name or doing business as (DBA) name (Required if legal name exceeds 50 characters and spaces)				
	Physical address		City	State	ZIP code
2.	**Mailing address**	Select one. ❍ Same as physical address ❍ Separate address, complete below			
	Street/PO Box		City	State	ZIP code
3.	**Billing address**	Select one. ❍ Same as mailing address ❍ Separate billing address, complete below			
	Street/PO Box		City	State	ZIP code
	Billing contact person			Area code & phone number	
	Email address				

4.	Employer identification number (EIN)	Standard Industrial Classification (SIC #)	North American Industry Classification System (NAICS #)
5.	Group benefit administrator contact		
	Area code & phone number	Email address	

6.	**Subgroup Structure**: Does your group have a specific subset of membership that is to be allocated to a different billing location or entity? Select one. ❍ No. Skip to section 7. ❍ Yes. Provide the following if different than above			
a.	Subgroup name		Employer Identification Number (EIN)	
	Subgroup billing contact	Subgroup benefit contact		
	Mailing address: street/PO Box	City	State	ZIP code
	Billing address	Select one. ❍ Same as mailing address ❍ Separate billing address, complete below		
	Billing address: street/PO Box	City	State	ZIP code
b.	Subgroup name		Employer Identification Number (EIN)	
	Subgroup billing contact	Subgroup benefit contact		
	Mailing address: street/PO Box	City	State	ZIP code
	Billing address	Select one. ❍ Same as mailing address ❍ Separate billing address, complete below		
	Billing address: street/PO Box	City	State	ZIP code
c.	Subgroup name		Employer Identification Number (EIN)	
	Subgroup billing contact	Subgroup benefit contact		
	Mailing address: street/PO Box	City	State	ZIP code
	Billing address	Select one. ❍ Same as mailing address ❍ Separate billing address, complete below		
	Billing address: street/PO Box	City	State	ZIP code
d.	Subgroup name		Employer Identification Number (EIN)	
	Subgroup billing contact	Subgroup benefit contact		
	Mailing address: street/PO Box	City	State	ZIP code
	Billing address	Select one. ❍ Same as mailing address ❍ Separate billing address, complete below		
	Billing address: street/PO Box	City	State	ZIP code

7.	If subject to Consolidated Omnibus Budget Reconciliation Act (COBRA), do you use a COBRA administrator? Select one. ❍ No. Use the same billing address and group contact person. ❍ Yes. Complete the information below.		
	COBRA administrator name. This is the name of the company.		
	COBRA contact person		Title
	Area code & phone number	Extension	Email address
	COBRA mailing address		
	City	State	ZIP code

C. Group eligibility

A large group employer is an employer who employed an average of at least 51 common law employees on business days during the preceding calendar year and who employs at least 51 common law employees on the first day of the current contract term. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a large group employer will be based on the average number of employees that it is reasonably expected to employ on business days in the current calendar year.

This count should include all full-time, seasonal, and union employees that work either inside or outside of the State of Alaska and employees worldwide from any affiliated company. Include business owners, corporate officers, and partners only if they are common-law employees. Contracted 1099 individuals should not be included. Common–law employees are defined under the Employee Retirement Income Security Act of 1974 (ERISA) and Internal Revenue Service (IRS) regulations, guidance, and case law. Consult with your legal counsel to ensure your employees are considered common-law employees under the law.

1.	Did the group employ an average of 51 or more employees during the previous calendar year? Select one. ❍ Yes ❍ No. Contact your sales representative.		
2.	Is the group made up of multiple business/employers? Select one. ❍ Yes. Complete section 2a. ❍ No. Skip to question 5.		
a.	Are the businesses parent-subsidiary or brother-sister companies, meeting the federal controlled group ownership requirements? Select one. ❍ Yes, Complete question 3. ❍ No. Skip to question 4.		
3.	Is the group a subsidiary of or affiliated with another company or headquartered outside the State of Alaska? Select one. ❍ Yes. Complete questions 3a and 4. ❍ No. Skip to question 4.		
a.	Legal name		
	Physical address		
	City	State	ZIP code

4.	Does the large group qualify as an employer under 29 U.S.C Sec. 1002(5)?? Select one. ❍ Yes. ❍ No. Contact your sales representative. **Note:** Multiple Employer Welfare Arrangements (MEWAs) and Associate Health Plan do not always qualify as an employer under 29 U.S.C Sec. 1002(f) (ERISA 3 (5). Only groups that qualify are eligible to purchase coverage as a large group.
5.	In the past 36 months has the group or any affiliated entity filed for protection or operated under federal/state bankruptcy laws? Select one. ❍ Yes ❍ No
6.	In the past 36 months has any creditor filed or threatened to file a petition requesting the group or any affiliated entity be put into bankruptcy? Select one. ❍ Yes ❍ No
7.	Is worker's compensation provided for all employees? Select one. ❍ Yes ❍ No. List employees not covered and reason: _____ _____

D.	**Group materials**	
1.	**Group contract** A contract signature is required within 90 days of your plan effective date. The final contract will be sent electronically through DocuSign for an electronic signature to the contract signer listed below. Once signed, a copy can be downloaded and accessed through the secure employer website**.**	
	Group authorized contract signer name	Email address
2.	**Benefit booklets** Copies of employee benefit booklets will be sent electronically and can be accessed online through the secure employer website. Add group logo to benefit booklet? Select one. ❍ Yes. Email logo to Premera Account Team. ❍ No	
3.	**ID numbers/cards** Member ID numbers will be available as soon as initial enrollment has been processed. ID cards will arrive approximately 7 to 10 business days later. Members can also get their ID cards through the Premera mobile app. Add group logo to ID cards? Select one. ❍ Yes. Email logo to Premera Account Team. ❍ No	
4.	**Enrollment method** A Premera enrollment spreadsheet will be provided for initial enrollment submission. Ongoing eligibility submitted via - select one. ❍ Electronic eligibility file (834EDI). Allow for set-up time. ❍ Premera's Enrollment Center (standard if not using an electronic eligibility file)	
	834 vendor's name	834 vendor's analyst contact name
	Area code & phone number	Email address

E. Current coverage information

1. Is this plan intended to replace any existing group coverage? Select one.

❍ No. Go to next section, Group Eligibility.
❍ Yes. Complete this section.

Name(s) of other medical carrier(s)	Name(s) of other dental carrier(s)	Name(s) of other vision carrier(s)
Termination date	Termination date	Termination date

2. Are you offering a plan or plans from a carrier other than Premera Blue Cross Blue Sheild of Alaska? Select one.

❍ No. Skip to section 6.
❍ Yes. More than one carrier's plan is offered. Complete the names below.

For medical carriers, check ☐ if the other health plan is a High Deductible Health Plan (HDHP).

Name(s) of other medical carrier(s)	**Name(s) of other dental carrier(s)**	**Name(s) of other vision carrier(s)**
☐		
☐		
☐		

New non-grandfathered groups with a plan effective date in the middle of the calendar year can ask Premera to apply credit toward members' out-of-pocket maximum on the group's new Premera plan. When the group provides the data, Premera will credit the members' coinsurance, copays, and deductible amounts required by the group's prior plan that the members paid in the same calendar year as the group's effective date under the new Premera plan.

3. Do you currently offer personal funding account products? (HRA, FSA, DCFSA, HSA) Select one.

❍ No
❍ Yes. Provide vendor name: _____

4. Will you be using our personal funding account vendor for your personal funding account administration? Select one.

❍ No
❍ Yes

F. Employee eligibility requirements

If all of your employees must work the same hours, meet the same probationary period, and will have the same benefits options available to them, complete Section 1 (omit 2), then continue to 3, 4, and 5.

If you are differentiating your employees by class (such as managers, hourly workers) complete Section 2 (skip 1), then continue to 3, 4, 5, and 6.

1. All Employees in One Class

a.

All employees who normally work a minimum of _____ hours* per week and have satisfied the probationary period are eligible.

***Note:** Employees must work at least 20 hours per week to qualify for health coverage. The group may choose to set the minimum number of work hours per week higher for employees to be eligible.

b. **Probationary period information**

All eligible employees are effective on the

❍ Exact date of hire OR

❍ First of the month following:	❍ Date of hire	❍ 30 days	❍60 days
❍ Next day following:	❍ Date of hire	❍ 30 days	❍ 60 days

2. Employees Differentiated by Class

Use the section above for the first class and this section for the second class.

a. **Minimum work hours and probationary period information**

Complete the minimum work hours* and probationary period information for each designated class of employee.

***Note:** Employees must work at least **20 hours** per week to qualify for health coverage. The group may choose to set the minimum number of work hours per week higher for employees to be eligible.

b. Select one:

❍ Salaried ❍ Hourly ❍ Full-time

c. All employees who normally work a minimum of _____hours*per week and have satisfied the probationary period, are eligible.

d. **Probationary period information - select one.**

All eligible employees are effective on the

❍ Exact date of hire OR

❍ First of the month following:	❍ Date of hire	❍ 30 days	❍60 days
❍ Next day following:	❍ Date of hire	❍ 30 days	❍ 60 days

3. Do you want to waive the probationary period for all current qualifying employees for this enrollment period? Select one.

❍ Yes. Waive the probationary period on all current qualifying employees, regardless of their hire date.

❍ No. Apply the probationary period to all employees. (We will apply the probationary period to employee's date of hire to calculate effective date.)

4. Coverage will end – select one

❍ Last day of the month for which the premium is paid

❍ Other: _____

5.	**Domestic partners** Will domestic partners be eligible for coverage: Select one. ❍ Yes ❍ No Will domestic partners be eligible for COBRA? Select one. ❍ Yes ❍ No
6.	**Common enrollment? Select one** ❍ Yes ❍ No **Note:** Any dependents must enroll in the same plan as the employee/subscriber offered by the group. This only applies to groups with Premera medical plans offering standalone Premera dental plans.

G. Employee enrollment

1.	Total number of employees on payroll (regardless of hours worked) **Note:** Count each employee in only one category	_____
2.	Total number of employees not eligible to enroll Employees working less than the minimum number of hours required per week, are in a probationary period, are temporary or seasonal, or not in covered class)	_____
3.	Total number of employees not enrolling due to other coverage	_____
4.	Total number of employees eligible to enroll (sections 1 – 2 – 3)	_____
5.	Total number of eligible employees waiving enrollment without other coverage	_____
6.	Estimated number of eligible employees enrolling (sections 4 – 5)	_____
	Please enter participation level as a percentage Calculate employee participation by dividing eligible employees enrolling (6) by the total number of employees waiving without other coverage (5). Participation percentages under 75% require underwriting approval.	_____
7.	Total number of retirees eligible for benefits	_____
8.	Total number of COBRA subscribers	_____
9.	Do you have eligible employees outside the state of Alaska? Select one. ❍ No ❍ Yes. Complete the table below.	

State or country	Number of employees

H. Employer contribution requirements

The following percentage or dollar amount will be contributed toward the cost of eligible employee and dependent coverage.

	Medical	Dental	Vision
Employee			
Spouse/Domestic Partner			
Dependent (1 child)			
Dependent children (2 or more)			

I. Federal requirements

Helpful hint: We strongly urge you to consult legal counsel in answering the questions below. The summaries below are not intended to be or to replace legal advice on your particular group. It is the group's responsibility to inform Premera immediately if facts change that would cause the group's answers below to change.

1. **Is the group subject to the federal Medicare secondary payer (MSP) laws** that prohibit discrimination against individuals with group coverage based on their (or a spouse's) current employment status who have **Medicare due to age**? Select one.

a.
❍ Yes. This plan will pay primary to Medicare as required by federal law.
❍ No. Under 20 employees

b. **Please also provide the number of employees who now meet Medicare's definition of "employee"** _____

These laws do not apply to any employer who did not employ 20 employees or more for each working day in each of 20 or more calendar weeks in either the current **or** preceding calendar year.

"Employees" include all full-time employees as well as those employees on disability and subject to FICA taxes. Also count leased employees if they would be counted as employees under §414(n)(2) of the Internal Revenue Code (IRC), and count employees employed by an "affiliated service group" under IRC §414(m), or by employers considered to be a "single employer" under IRC §52(a) or (b).

2. **Is the group subject to COBRA?** Select one.
❍ Yes
❍ No. Give the legal reason for exemption: _____

Generally, these laws apply to any non-church employer that employed 20 or more employees on at least 50% of its working days in the preceding calendar year.

"Employees" are full-time and common-law employees. Self-employed workers as defined in IRC §401has (1), corporate directors, or independent contractors should not be counted unless they qualify as common-law employees. "Employees" may also include leased employees who qualify as common-law employees.

3. **Is the group subject to the federal Medicare secondary payer (MSP) laws** that prohibit discrimination against individuals with group coverage based on their (or a family member's) current employment status who have **Medicare due to a disability**? Select one.

a.
❍ Yes. This plan will pay primary to Medicare as required by federal law.
❍ No. Under 100 employees

b.	**Please also provide the number of employees who now meet Medicare's definition of "employee" _____** Generally, these laws apply to any employer that employed at least 100 employees on 50% or more of its working days in the preceding calendar year. See the helpful hint in 6 above for a definition of "employee" for this purpose.
4.	**Is the group subject to the Employee Retirement Income Security Act (ERISA)?** Select one. ❍ Yes. Enter the month the ERISA plan year ends: Month: _____ ❍ No. Give the legal reason for exemption: ☐ Government or public plan ☐ Church plan ❍ Other. Please specify: _____
	Generally, ERISA applies to all employer health plans except governmental, public, or church plans. Nonprofit status alone does not exempt an employer from ERISA.

J. Producer agreement to contract

1.	Producer of record name		Producer number
	Area code & phone number	Email address	
	Name of firm/agency		
	Medical commission	Per employee per month (PEPM)	Percentage
	Dental commission	PEPM	Percentage
2.	**Producer support contacts**		
	Contact name 1	Area code & phone number	Email address
	Contact name 2	Area code & phone number	Email address
3.	**Split commission**		
	Secondary producer name		Secondary producer number
	Commissions are split between the primary and secondary producer as follows Primary _____% Secondary_____%		

You, the producer(s), certify that you have met with the group submitting this agreement and that you have fully explained its contents. You have discussed coverage, eligibility, the effect of misrepresentations, termination provisions, and premium billing administration.

Producer signature X _____	Producer of record (print name) Date signed

K. Group agreement to contract

You, the group named in Section B of this application, understand, and agree to the following.

1. **This application becomes part of the contract to provide healthcare coverage after:**

- The application is signed by you;
- The application is received and approved by us; and
- We receive the initial month's premium.

You may not assign this contract without our written consent. Any attempt to do so will not have any binding effect on us. You agree to promptly deliver materials and notifications, including benefit booklets, received from us to all covered employees. You also agree to provide notification regarding the plan's special enrollment rights to all eligible employees before their enrollment. You attest to have read this application and represent that all statements are true and complete.

You agree to the terms and obligations stated in this application. It is understood that provisions of the Health Care Contract, including premiums, may be amended, or changed from time to time, upon our notice to you. All prior applications, to the extent that you have not made changes to them in this application, remain in full force and effect. The producer listed in the producer agreement to contract section will remain effective until written notice is given by either party. We are authorized to pay, on your behalf, commission, if any, for which you are liable to the above-named producer. Completed materials should be received 45 days prior to the effective date.

Paperwork received after the 45 days will likely experience delays in receiving the following:

- ID cards
- Access to pharmacy benefits
- Benefit booklets
- Initial billing statement
- Access to HSA funds (if selected), for employee reimbursement of claims activities incurred prior to the HSA set-up being complete

You understand these potential impacts to your employees and their families listed above if enrollment materials are received after this date and will inform them of these impacts should the materials be received late.

2. You may elect to allow the producer listed above to act as a group benefit administrator beginning on the group's effective date. This means that the producer/administrator will be able to access membership and billing functions and obtain information about group members via the web on behalf of the group.

These functions include, but are not limited to:

- View benefit detail
- Inquire about eligibility
- Reinstate terminated members
- Invoices: inquire about or request invoices
- View group demographic information
- Order ID cards for an individual or whole family
- Members: search for members, enroll or cancel a member

Do you elect and authorize Premera Blue Cross Blue Shield of Alaska to provide such information to the producer and producer support staff? (Is the Producer authorized as group administrator?) Select one.

❍ No
❍ Yes

3. I affirm that this group is eligible to purchase coverage as a large employer under state and federal law and has a physical location in the State of Alaska, and I am authorized to sign on behalf of the group.

Signature of group's representative	Group's representative (print name)	
X _____	Title	Date signed

Note: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.