PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Small Group Master Application (New Groups)

Application is made to Premera Blue Cross Blue Shield of Alaska (hereafter referred to as "we," "us," or "our") for a new healthcare 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.

Group name	Requested effective date

A.	**Group information**			
1.	Legal name:			
	Common name **Note:** Required if Legal Name exceeds 43 characters and spaces, otherwise, optional.			
	Employer identification number (EIN)		NAICS #	
	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 ❍ Same as physical ❍ Separate address, complete below		
	Street/PO Box			
	City	State	ZIP code	
4.	Group contact person		Title	
	Phone – include area code	Email address		
5.	Billing contact person		Title	
	Phone – include area code	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? ❍ No ❍ Yes. Provide the following if different than billing contact and address above.			
	Subgroup name		Employer identification number (EIN)	
	Subgroup billing contact		Subgroup benefit contact	
	Mailing address	Street/PO Box		
	City	State	Zip code	
	Billing address	Street/PO Box		
	City	State	Zip code	
7.	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 administrator billing address			
	City	State	Zip code	
	COBRA administrator contact person			
	Phone – include area code	Extension	Email address	

B. Current coverage information

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

❍ No. Go to next section, Group Eligibility.

❍ Yes. Complete this section.

1.	Current medical carrier's name:
	Group number
	Termination date
2.	Current dental carrier's name
	Group number
	Termination date

C. Group eligibility

A small employer is an employer who employed an average of at least 1 but not more than 50 common law employees on business days during the preceding calendar year and who employs at least 1 common law employee on the first day of the current plan 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.

In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer should be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year. Sole proprietors with no common law employees and self-employed individuals are not eligible to purchase (or renew) small group plans.

1.	Did the group employ an average of 1-50 or fewer employees during the previous calendar year? Select one. ❍ Yes ❍ No
2.	Is the company's headquarters located in the State of Alaska? Select one. ❍ Yes ❍ No. Please contact your Sales Representative for assistance .

D. Employee eligibility requirements

If all of your employees must work the same hours, meet the same probationary period, and will have the same benefit options available to them, complete sections 1 and 3, skip section 2.

1.	**Employees in one class** **Note:** Class of employees must be based on bona fide employment-based classifications consistent with your usual business practice.
a.	Choose one: ❍ All Employees ❍ Salaried ❍ Hourly ❍ Full-time
b.	All employees who normally work a minimum of _____ hours* per week, have satisfied the probationary period, are eligible.
c.	**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** **Note:** Use the section above for the first class and this section for the second class
a.	Choose one: ❍ All Employees ❍ Salaried ❍ Hourly ❍ Full-time
b.	All employees who normally work a minimum of _____ hours* per week, have satisfied the probationary period, are eligible.

c.	**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			
3.	**Waive probationary period** Do you want to waive the probationary period for all current qualifying employees for this enrollment period? Select one. ❍ No ❍ Yes			

E. Employer contribution and employee participation requirements

Premera Blue Cross Blue Shield of Alaska minimum contribution / participation requirements (applicable to all small groups)

Group Size	Employer Contribution	Participation	Employer Contribution	Participation
	Employees		Dependents	
Medical				
1 – 3 Eligible Employees	75%	100%	No required level*	Optional
4 – 50 Eligible Employees	50%	75%	No required level*	Optional
Dental				
2 – 4 Eligible Employees	50%	100%	No required level*	Optional
5 – 50 Eligible Employees	50%	Greater of 5 Enrolled Employees or 50% of Eligible Employees	No required level*	Optional
Voluntary Dental				
2 or more Eligible Employees	0-49%	Greater of 5 Enrolled Employees or 30% of Eligible Employees	No required level*	Optional

Note: Employer contribution for dependent coverage cannot exceed the contribution for employee coverage.

Employer contribution levels

As the Employer, you will contribute the following percentage toward the cost of eligible employee and dependent coverage:

	Medical	Dental
Contribution for Employees:	_____%	_____%
Contribution for Dependents:	_____%	_____%

***Note for 1-50 Groups:** If the employer contributes 100% of the employee cost of coverage, then 100% participation is required of eligible employees without other coverage.

Please note: If a group does not meet the requirements above, the group may enroll during the next designated open enrollment period.

F. Employee enrollment

		Medical	Dental
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, not in covered class	_____	_____
3.	Total number of employees eligible to enroll Note: Calculated by subtracting total number of employees not eligible to enroll (2) from total employees on payroll (1)	_____	_____
4.	Total number of employees not enrolling due to coverage under other group coverage or a government plan (Medicare, Medicaid, CHAMPUS/Tricare, or Military)	_____	_____
5.	Eligible employees waiving enrollment without other group coverage (listed above)	_____	_____
6.	Total number of eligible employees enrolling	_____	_____
	Please enter participation level as a percentage **Note:** Participation level calculated by dividing the total number of employees enrolling (6) by the total number of eligible employees without other group coverage (3–4).	_____	_____
7.	Do you have eligible employees in Hawaii? Select one. ❍ No ❍ Yes **Note**: Employees who reside in the state of Hawaii are not eligible for coverage.		

G. 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 (such as TEFRA) 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."_____
	Helpful hint: 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 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 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 disability?
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" _____
	Helpful hint: 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 question **G.1** above for a definition of "employee" for this purpose.

3.	Is the group subject to COBRA? Select one. ❍ Yes ❍ No, give the legal reason for exemption: _____
	Helpful hint: Generally, these laws apply to any non-church employer that employed 20 employees 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 §401(c)(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.
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: _____
	Helpful hint: Generally, the Employee Retirement Income Security Act (ERISA) applies to all employer health plans except governmental, public, or church plans. Nonprofit status alone does not exempt an employer from ERISA.

H. Group materials

Benefit Booklets: Electronic copies of your group's benefit booklets can be accessed through the secure employer website and are available online at premera.com.

ID numbers/cards: Member ID numbers will be available as soon as initial enrollment has been processed.ID cards will arrive approximately 7-10 business days later, but can also be accessed through the Premera mobile app.

J. Producer agreement to contract

You, the producer, 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 of record

Producer signature X _____	Producer of record (print name)	
	Date signed	Producer number
Producer email address	Name of firm/agency	
Effective date producer is appointed for this group		

Producer support contact	
Contact name (1)	Email address (1)
Contact name (2)	Email address (2)
Secondary producer and commission	
Secondary producer name	Secondary producer number

❍ Split commission
Commissions are split between primary and secondary producer as follows: Primary_____% Secondary_____%

K. Group agreement to contract

You, the group named in the Group information section 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 waiting period and 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 subscription charges, 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 complete application consists of this document and the completed Small Group Benefit Selection Worksheet.

Paperwork received after the 10th of the month prior to the effective date may cause delays in receiving the following:

- Benefit booklets
- Access to benefits
- Initial billing statement

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.

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 to allow Premera Blue Cross to provide such information described above to the producer? Select one.

❍ No
❍ Yes

3.	New groups, with a plan effective date in the middle of their plan year, can request the cost-sharing, (such as deductible, coinsurance, and copay), amounts accrued prior to the plan effective date be credited to their new plan.		
4.	I affirm the contribution and participant requirements in **Employer Contribution and Eligible Employee Participation Requirements** are followed. (Applicable to groups renewing outside open enrollment).		
5.	I affirm that this group 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 X _____	Group's representative (print name) Print title	Date signed
	Note: A person who, with intent to injure, defraud, or deceive, knowingly makes a false or fraudulent statement or representation in or with reference to an application for insurance, may be prosecuted under state law.		

Notice of availability and nondiscrimination **800-508-4722 | TTY: 711**

Call for free language assistance services and appropriate auxiliary aids and services.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Hu thov kev pab txhais lus pub dawb thiab lwm yam khoom pab dawb thiab kev pab cuam ua tsim nyog.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Vala‘au mo auaunaga tau fesoasoani mo gagana e leai ni totogi ma fesoasoani fa‘aopo‘opo talafeagai ma auaunaga.
ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
Tumawag para kadagiti libre a serbisio iti tulong iti pagsasao ken dagiti nakanada nga aid ken serbisio iti komunikasion.
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
ติดต่อขอบริการช่วยเหลือด้านภาษาฟรีพร้อมความช่วยเหลือและบริการอื่น ๆ เพิ่มเติม
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d’assistance linguistique et des aides et services auxiliaires appropriés.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

Discrimination is against the law. Premera Blue Cross Blue Shield of Alaska (Premera) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex. Premera provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, TTY: 711, Fax: 425-918-5592, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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