OptiFlex group master application

Grandfathered / Non-Grandfathered: 51+ enrolled employees

Application is made to Premera Blue Cross (hereafter referred to as "we," "us," or "our") for a new administrative services contract. Your group cannot be enrolled prior to our receipt date of this completed and signed application.

1 Account Information

Contract Period: **To:**		**Renewal Month:**	
Legal employer name:			
Common employer name: (Note: Required if legal name exceeds 43 characters and spaces, otherwise, optional.**)**			
Type of business:	Employer Identification Number (EIN):	SIC #:	NAICS #:
Physical address:			
City:	State:	ZIP code:	County:
Mailing address (if different from Physical Address):			
City:	State:	ZIP code:	County:
Is the group headquartered in Washington? ☐ Yes ☐ No If no, please contact your Sales Representative			
Is the self-funded group health plan considered an Association, MEWA or other Employer-Member Governed Group? ☐ Yes ☐ No If yes, please contact your Sales Representative			
Is the group a subsidiary of or affiliated with another company meeting the federal Controlled Group ownership requirements? ☐ Yes ☐ No			
Subsidiaries or affiliated companies (if applicable):			
Address:			
City:	State:	ZIP code:	County:
Group Contact:		Title:	
Phone Number:	Email Address:		
Billing Contact (if different from above):		Title:	
Phone Number:	Email Address:		
Do you use a COBRA Administrator: ☐ Yes ☐ No		Would you like the COBRA bill mailed to your COBRA Administrator: ☐ Yes ☐ No	
COBRA Administrator:		**COBRA Contact Name:**	
Phone Number:	Email Address:		
COBRA Mailing address:			

PO Box 327, MS 315
Seattle, WA 98111-0327

PREMERA | BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

City:	State:	ZIP code:	County:
In the past 36 months has the group or any affiliated entity filed for protection or operated under Federal/State Bankruptcy laws? ☐ Yes ☐ No			
In the past 36 months has any creditor filed or threatened to file a petition requesting the group or any affiliated entity to be put into bankruptcy? ☐ Yes ☐ No			

2 Eligibility Requirements

Subgroup Setup

Standard subgroups are Active and COBRA. Additional subgroups may be added to accommodate separate billing addresses.

Subgroup Name	Subgroup Contact Name (if different)	Subgroup Billing Address (if different)

Note: *If more than 6 subgroups, attach additional subgroup information.*

Employee Classes

New employees, (after initial enrollment of the group), will be eligible for coverage based on the following minimum work hours* and probationary period information. If all employees fall in to one Class, notate "all employees" in the first line and make the hour and probationary period selections:

Class Description	Minimum Hours	Probationary Period		
		Option 1	Option 2	Option 3
		☐ Exact date of hire	1st of the month following: ☐ Date of hire ☐ 30 Days ☐ 60 Days ☐ Other: _______	Next day following: ☐ 30 Days ☐ 60 Days ☐ Other: _______
		☐ Exact date of hire	1st of the month following: ☐ Date of hire ☐ 30 Days ☐ 60 Days ☐ Other: _______	Next day following: ☐ 30 Days ☐ 60 Days ☐ Other: _______
		☐ Exact date of hire	1st of the month following: ☐ Date of hire ☐ 30 Days ☐ 60 Days ☐ Other: _______	Next day following: ☐ 30 Days ☐ 60 Days ☐ Other: _______
		☐ Exact date of hire	1st of the month following: ☐ Date of hire ☐ 30 Days ☐ 60 Days ☐ Other: _______	Next day following: ☐ 30 Days ☐ 60 Days ☐ Other: _______
		☐ Exact date of hire	1st of the month following: ☐ Date of hire ☐ 30 Days ☐ 60 Days ☐ Other: _______	Next day following: ☐ 30 Days ☐ 60 Days ☐ Other: _______
		☐ Exact date of hire	1st of the month following: ☐ Date of hire ☐ 30 Days ☐ 60 Days ☐ Other: _______	Next day following: ☐ 30 Days ☐ 60 Days ☐ Other: _______

Note: *Probationary period cannot be more than 60 days following the member's eligibility date. If more than 6 Classes, attach additional Class information. *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.*

Eligibility Setup

Waive the probationary period:

- ☐ Waive the probationary period on all current qualifying employees
- ☐ Apply the probationary period to all employees (current employees must satisfy the balance of the above probationary period)

Would you like coverage to end the last day of the month: ☒ Yes ☒ Other:

New Spouses and Stepchildren will be effective: ☐ Marriage date ☐ First of the month following marriage

Dependent children termination: ☐ Actual birthday ☐ Last day of the month in which birthday occurs

Student & dependent age: *The limiting age for covered children is **twenty-six (26) years**, regardless of presence or absence of a child's financial dependency, residency, student status, employment, marital status, or any combination of those factors.*

Cover Domestic Partners? ☐ Cover registered and unregistered ☐ Cover registered only ☐ Do not cover

Offer COBRA rights to domestic partners? ☒ Yes ☒ No

3 Employee Enrollment Information

A. Total Number of employees on payroll regardless of hours worked: _____
Note: For 3B and 3C count each employee in only ONE category.

B. Employees not eligible to enroll:
Employees who work less than the minimum hours per week (as specified in section 2)
Employees who are temporary or seasonal _____
Employees who are in a probationary period _____
Employees who are not in a covered class (employees not eligible in section 2) _____
Total B: _____

C. Employee not enrolling due to other Coverage under: _____
Government Plan *(e.g. Medicare, CHAMPUS/Tricare, Military)* _____
Other group coverage _____
Collective bargaining agreement (Union) _____
Total C: _____

D. Total number of employees eligible to Enroll (section 3A-3B-3C) _____

E. Eligible employees waiving enrollment without other coverage _____

F. Total number of eligible employees enrolling (section 3D-3E) _____

G. Total number of retirees eligible for benefits _____

H. Total number of COBRA/Continuation of Coverage subscribers _____

I. Do you have eligible employees employed outside the State of Washington?

☐ No ☐ Yes, complete following table:

State/Country	Number of employees

J. Calculated actual % of participation (Completed by PBC) _____

4 Employer Contribution

Note: *Waivers of coverage are not allowed for eligible employees of non-contributory groups. If dependent coverage is also non-contributory, no waivers of coverage allowed. If you differentiate contributions by class of employee, those same classes must be represented here.*

Effective date of contribution:			
	Medical	**Dental**	**Vision**
Employee			
Spouse/Domestic Partner			
Dependent Child (1 Child)			
Dependent Children (2 or more)			

5 Current Coverage Information

Is this Premera Blue Cross plan intended to replace any existing coverage? ☐ Yes ☐ No	
Name(s) of Medical carrier(s) being replaced:	**Proposed termination date:**
Name(s) of Dental carrier(s) being replaced:	**Effective date of coverage:** **Proposed termination date:**
Does the dental plan being replaced include orthodontia? ☐ Yes ☐ No	**If Yes, effective date of orthodontia coverage:**
Name(s) of Vision carrier(s) being replaced:	**Proposed termination date:**
Are you offering a plan or plans from a carrier other than Premera Blue Cross? ☐ Yes ☐ No, go to next section	

Name(s) of other Medical carrier(s)	**Name(s) of other Dental carrier(s)**	**Name(s) of other Vision carrier(s)**

6 Personal Funding Account Information

Do you currently offer HSA bank account administration: ☐ Yes ☐ No, go to next section
Will your HSA bank account administration remain with your current vendor: ☐ Yes ☐ No **If yes, vendor name:**
Or will you move your HSA account administration to our vendor: ☐ Yes ☐ No

7 Enrollment and Billing Process

Contracts and Benefit Booklets

Note: *Benefit Booklets will be made available electronically or on Premera.com. Printed copies available upon request.*

Final contracts sent to: ☐ Producer ☐ Group Administrator ☐ Other: _____

Member Enrollment

A spreadsheet template will be provided for initial enrollment submission
Ongoing eligibility submitted via: ☐ 834 File from group (please allow for setup time) ☐ Online via the Employer Administration Portal
If offering medical and dental plans with Premera, will you require common enrollment: ☐ Yes ☐ No ☐ Not Applicable **Note:** *Only applies to groups with medical plans offering standalone dental plans. If not offering standalone plans, this is not applicable.*
Will the prior carrier submit a deductible and out-of-pocket maximum balance report: ☐ Yes ☐ No If no, individual member credit forms may be submitted. The member credit form is available on our website at **https://www.premera.com/documents/008756.doc**

8 Legal and Regulatory 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 which would cause the group's answers below to change.*

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?

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

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. For these small group plans, Medicare pays primary to the group plan. "Employees" include all full-time and part-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).*

Is the group subject to COBRA?

- ☐ Yes
- ☐ No **Give the legal reason for exemption:** _____

Helpful Hint: *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 part-time 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. Please see COBRA regulations at 26 CFR § 54.4980B-2 Q/A 5 for guidance on counting a part-time employee as a fraction of a full-time employee.*

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?

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

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. "Employees" include all full-time and part-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).*

Massachusetts (MA) 1099 Reporting:
Does the group have any employees that reside in the state of Massachusetts (MA)? ☐ Yes ☐ No

The Massachusetts Health Care Reform Act requires groups to provide, or contract with another entity to provide, a written statement to individuals residing in Massachusetts who had "creditable coverage" at any time during the prior calendar year through the employer's group health plan and to file a separate electronic report to the Massachusetts Department of Revenue verifying information in the individual written statements.

Is the group subject to ERISA: ☐ Yes ☐ No
If no, legal reason for exemption: ☐ Government or Public Plan ☐ Church Plan ☐ Other: _____

Helpful Hint: *Generally, ERISA applies to all employer health plans except governmental, public or church plans. Non-profit status alone does not exempt an employer from ERISA.*

ERISA Plan #: _____ **Month ERISA plan year ends:** _____ **ERISA Plan Administrator:** _____

9 Other Provisions and Administrative Selections

Would you like to offer free credit monitoring through Experian to your members: ☐ Yes ☐ No

Member Engagement Outreach:

☐ **Option A** (granting permission to both Premera and its vendors): Plan Sponsor agrees that, and grants permission for, the following personal data to be used by the Claims Administrator, and shared with Claims Administrator's vendors who provide a health plan benefit service for use, for the purpose of sending directed notifications to members regarding programs and services included in their health plan benefits: member name, member address, member email and phone number.

☐ **Option B** (granting permission to only Premera) Plan Sponsor agrees that, and grants permission for, the following personal data to be used by the Claims Administrator, for the purpose of sending directed notifications to members regarding programs and services included in their health plan benefits: member name, member address, member email and phone number.

☐ **Option C** Plan Sponsor does not agree that, nor grant permission for, the following personal data to be used by the Claims Administrator or Claims Administrator's vendors who provide a health plan benefit service for the purpose of sending directed notifications to members regarding programs and services included in their health plan benefits: member name, member address, member email and phone number.

**Opting out at the group level will not impact other products or programs that include targeted member outreach such as Personal Health Support or Livongo*

10 Producer and Commission

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 subscription charge billing administration.

Producer Agency:		**Effective Date of Appointment:**
Producer Name:	**Producer Number:**	
Phone Number:	**Email Address:**	
Producer Signature:		
Commission: _____ PEPM **Split commission:** ☐ Yes ☐ No		**Secondary Producer Amount:** _____ PEPM
Secondary Producer Agency:		**Effective Date of Appointment:**
Secondary Producer Name:	**Secondary Producer Number:**	
Phone Number:	**Email Address:**	

11 Group Agreement to Contract

You, (the group named in **section 1** of this application), understand and agree to the following:
This application becomes part of the contract to provide third party administration services for the Group's self-funded plan(s) after:

- The application is signed by you;
- The application is received and approved by us; and

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 special enrollment rights to all eligible employees before their enrollment. You attest to have read this application and certify that all statements are true and complete. You agree to the terms and obligations stated in this application. 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 section above 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 must be **received 30 days prior to the effective date**. Enrollment materials received after these 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.

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 may include, but are not limited to:

- Reinstate terminated members
- Request invoice
- Search for a member
- View benefit detail
- Inquire on invoice
- Inquire on eligibility
- Enroll a member
- Order ID cards for an individual or whole family
- View group demographic information
- Cancel a member

Do you elect and authorize Premera Blue Cross to provide such information to the producer and their staff? ☐ Yes ☐ No

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.

I affirm that this group is considered an employer under ERISA, is not considered a MEWA (or has already been provided special dispensation from the Office of the Insurance Commissioner as a self-funded MEWA), has a physical location outside Clark County in the State of Washington, and I am authorized to sign on behalf of the group.

Group Representative Signature: _____ **Date:** _____

Group Representative (Print Name): _____ **Title:** _____

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.*

TRACKING INFORMATION—TO BE COMPLETED BY PREMERA BLUE CROSS

Date Received by Sales: _____ Information Complete: ☐ Yes ☐ No Date Missing Information Received:

Account Manager/Sales Executive: _____ Extension: _____ Rep. Code: _____

Sales Support Contact: _____ Extension: _____ Sales Distribution: _____