PREMERA | BLUE CROSS

PO Box 91060
Seattle, WA 98111

Grandfathered / Non-grandfathered 51+enrolled employees

Self-Funded Employer Group Application

Application is made to Premera Blue Cross (hereafter referred to as "Premera", "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.

A. Account information

1.	Contract period MM/DD/YYYY From date _____ To date _____			Renewal month
	Legal name			
	Common name **Note**: Required if legal name exceeds 43 characters and spaces, otherwise, optional.			
	Type of business		Employer Identification Number (EIN)	
	Standard Industrial Classification (SIC#)		North American Industry Classification System (NAICS#)	
	Physical address (No PO Box/PMB)			
	City	State	ZIP code	County
	Group contact person		Title	
	Phone – include area code	Email address		
2.	**Mailing Address**	Select one. ❍ Same as physical address	❍ Separate address, complete below	
	Street/PO Box			
	City	State	ZIP code	County
3.	**Billing address**	Select one. ❍ Same as physical address	❍ Separate address, complete below	
	Street/PO Box			
	City	State	ZIP code	County
	Billing contact person if different from group contact.		Title	
	Phone – include area code	Email address		
4.	**Is the group headquartered in Washington? Select one.** ❍ Yes ❍ No. Contact your sales representative.			
5.	**Is the self-funded group health plan considered an association, Multiple Employer Welfare Arrangement (MEWA), or other employer-member governed group? Select one.** ❍ Yes. Contact your sales representative. ❍ No			

6.	**Consolidated Omnibus Budget Reconciliation Act (COBRA)**			
	Do you use a COBRA administrator? Select one. ❍ Yes. **Would you like the COBRA bill mailed to your COBRA administrator? Select one.** ❍ Yes. Complete section A7. ❍ No. Continue to section A8. ❍ No. Continue to section A8.			
7.	COBRA administrator name, the name of the company.			
	Street/PO Box			
	City	State	ZIP code	
	COBRA contact name			
	Phone – include area code	Email address		
8.	**Miscellaneous information**			
	Is the group a subsidiary of or affiliated with another company or headquartered outside Washington state? Select one. ❍ Yes. Complete the following. ❍ No. Continue to section B.			
	Legal name			
	Physical address			
	City	State	ZIP code	County
	In the past 36 months has the group or any affiliated entity filed for protection or operated under federal or state bankruptcy laws? Select one. ❍ 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? Select one. ❍ Yes ❍ No			

B. Eligibility requirements

Subgroup setup

Standard subgroups are Active and COBRA. Additional subgroups may be added to accommodate separate billing addresses. **Note**: If there are more than six subgroups, attach additional subgroup information.

Subgroup name	Subgroup contact name (if different)	Subgroup billing address (if different)

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 into one class, notate "all employees" in the first line and make the hour and probationary period selections.

Note: Probationary period cannot be more than 60 days following the member's eligibility date. If more than six 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

Class description	Minimum hours	Probationary period Option 1	Probationary period Option 2	Probationary period Option 3
		❍ Exact date of hire	First of the month following: Select one. ❍ Date of hire ❍ 30 days ❍ 60 days ❍ Other _____	Next day following: Select one. ❍ 30 days ❍ 60 days ❍ Other _____
		❍ Exact date of hire	First of the month following: Select one. ❍ Date of hire ❍ 30 days ❍ 60 days ❍ Other _____	Next day following: Select one. ❍ 30 days ❍ 60 days ❍ Other _____
		❍ Exact date of hire	First of the month following: Select one. ❍ Date of hire ❍ 30 days ❍ 60 days ❍ Other _____	Next day following: Select one. ❍ 30 days ❍ 60 days ❍ Other _____
		❍ Exact date of hire	First of the month following: Select one. ❍ Date of hire ❍ 30 days ❍ 60 days ❍ Other _____	Next day following: Select one. ❍ 30 days ❍ 60 days ❍ Other _____
		❍ Exact date of hire	First of the month following: Select one. ❍ Date of hire ❍ 30 days ❍ 60 days ❍ Other _____	Next day following: Select one. ❍ 30 days ❍ 60 days ❍ Other _____
		❍ Exact date of hire	First of the month following: Select one. ❍ Date of hire ❍ 30 days ❍ 60 days ❍ Other _____	Next day following: Select one. ❍ 30 days ❍ 60 days ❍ Other _____

Eligibility setup

Would you like to waive the probationary period? Select one.

- ❍ Yes. Waive the probationary period on all current qualifying employees regardless of their hire date provided it is on or before the effective date of the group.
- ❍ No. Apply the probationary period to all employees (use the employee's original date of hire and apply the group's probationary period to determine their effective date).

Grandfathered plans – Would you like to waive the transplant waiting period? Select one.

- ❍ Yes
- ❍ No

Would you like coverage to end on the last day of the month? Select one.

- ❍ Yes
- ❍ Other date. Specify _____

New spouses and stepchildren will be covered starting on what date? Select one.

- ❍ Marriage date
- ❍ First of the month following marriage

Newborn enrollment will follow the Erin Act*? Select one.

- ❍ Yes
- ❍ No

*The Washington Erin Act requires automatic coverage for newborns for the first 21 days of life, if mother's pregnancy was covered under the plan.

Children covered due to legal guardianship starting on what date? Select one.

- ❍ Date of guardianship order
- ❍ First of the month following order date

Foster children coverage starting on what date? Select one.

- ❍ Date of guardianship order
- ❍ First of the month following order date

Dependent children's plan coverage ends on what date? Select one.

- ❍ Actual birthday
- ❍ Last day of the month in which birthday occurs

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

Do you wish to extend the age limit for covered children who are full-time students and age twenty-six (26) or older?

- ❍ Yes. Age limit is _____
- ❍ No

Does the plan cover domestic partners? Select one.

- ❍ Cover registered and unregistered
- ❍ Cover registered only
- ❍ Do not cover

Does the plan offer COBRA rights to domestic partners? Select one.

- ❍ Yes
- ❍ No

C. Employee enrollment information

1. **Total number of employees on payroll regardless of hours worked** _____

   Note: For C2 and C3 count each employee in only ONE category.

2. **Employees not eligible to enroll:**

   Employees who work less than the minimum hours per week (as specified in section B) _____

   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 B) _____

   Total of section C2 _____

3. **Employees not enrolling due to other coverage under:**

   Government Plan: Medicare, CHAMPUS/Tricare, Military. _____

   Other group coverage _____

   Collective bargaining agreement (Union) _____

   Total of section C3 _____

4. Total number of employees eligible to enroll (section C1 – C2 – C3) _____
5. Eligible employees waiving enrollment without other coverage _____
6. Total number of eligible employees enrolling (section C4 – C5) _____
7. Total number of retirees eligible for benefits _____
8. Total number of COBRA/Continuation of coverage subscribers _____
9. Calculated actual % of participation (Completed by PBC) _____

Do you have eligible employees outside Washington state?

- ❍ Yes. Complete the fields below.
- ❍ No

State or country	Number of employees

D. 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 are allowed. If you differentiate contributions by class of employee, those same classes must be represented here.

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

Start date of contribution: MM/DD/YYYY_____

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

E. Current coverage information

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

- ❍ Yes. Complete the fields below.
- ❍ No. Continue to section F.

Name(s) of medical carrier(s) being replaced	Proposed end date MM/DD/YYYY
Name(s) of dental carrier(s) being replaced	Start date of coverage MM/DD/YYYY
	Proposed end date MM/DD/YYYY
Does the dental plan being replaced include orthodontia? Select one. ❍ Yes ❍ No	If yes, start date of orthodontia coverage MM/DD/YYYY
Name(s) of vision carrier(s) being replaced	Proposed end date MM/DD/YYYY

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

- ❍ Yes. Complete the fields below.
- ❍ No. Continue to section F.

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

F. Personal funding account information

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

- ❍ Yes

  Funding account options. Select one.

  - ❍ Funding account products will remain with the current vendor.

    If yes, provide vendor name: _____

  - ❍ HSA bank account administration will move to Premera's vendor.

    If yes, list products: _____

- ❍ No. Continue to section G.

G. 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.

Send final contracts to the following. Select all that apply.

- ☐ Producer
- ☐ Group administrator
- ☐ Other. Specify: _____

Group logo on booklets? Select one.

- ❍ Yes
- ❍ No

Will the group provide Premera plan-specific summary plan description (SPD) information to be included in the benefit booklets (ERISA groups only)? Select one.

- ❍ Yes
- ❍ No

Member enrollment

A spreadsheet template will be provided for initial enrollment submission.

Ongoing eligibility submitted via the following. Select one.

- ❍ 834 file from group (allow for setup time)

  If yes, name of 834 vendor:_____

- ❍ Online via the employer portal
- ❍ Paper enrollment form, if custom send copy to Premera for review.

If offering medical and dental plans with Premera, will you require common enrollment? Select one.

- ❍ Yes
- ❍ No
- ❍ Not applicable

Note: Only applies to groups with medical plans offering standalone dental and/or vision plans. If not offering standalone plans, this is not applicable.

Will the prior carrier submit a deductible and out-of-pocket maximum balance report? Select one.

- ❍ Yes
- ❍ No. Individual member credit forms may be submitted. The member credit form is available on our website at https:/premera.com/documents/008756.pdf

Group logo on ID cards? Select one.

- ❍ Yes
- ❍ No

Billing setup

Claims payment method. Select one.

- ❍ Electronic funds transfer (EFT) pull by Premera – must complete ACH form
- ❍ EFT push by group

Stop loss payment method. Select one.

- ❍ EFT pull by Premera – must complete ACH form
- ❍ EFT push by group
- ❍ Check

Administrative fee payment method. Select one.

- ❍ EFT push through Premera employer portal
- ❍ Check

RX rebate delivery method (if electing to receive RX rebates).Select one.

- ❍ EFT to group – must complete ACH form
- ❍ Paper check mailed to group

Invoice and report distribution

Note: List any group and producer representatives that would like to receive the invoice and reports noted below. A separate self-funded health plan information recipient list form will be provided by the sales team for completion. The individuals listed below must be included on the form.

Name	Email	Weekly claims invoice	Weekly paid claim detail report	Monthly paid claim detail report	Monthly stop loss invoice	Monthly large claim report	Monthly group experience report
		☐	☐	☐	☐	☐ Identifiable ☐ Non-identifiable	☐
		☐	☐	☐	☐	☐ Identifiable ☐ Non-identifiable	☐
		☐	☐	☐	☐	☐ Identifiable ☐ Non-identifiable	☐
		☐	☐	☐	☐	☐ Identifiable ☐ Non-identifiable	☐

H. Other provisions and administrative selections

Class action recovery. Select one.

- ❍ Yes. We do want to participate in class action lawsuits when Premera pursues settlements.
- ❍ No. We do not want to participate in class action lawsuits when Premera pursues settlements.

Description: Self-funded groups can choose to participate when Premera pursues settlements in class action lawsuits. Premera fees for the service will be shared proportionately by participating groups and will be taken as a percentage of the recovery amount. Each group will pay a percentage of a fixed amount based on the percentage of total recovery amount that Premera recovered on behalf of the group.

Coordination of benefits (COB) options. Select one.

- ❍ Coordinate to Premera allowable plus accrue and pay COB savings for claims incurred in the same calendar year.
- ❍ Coordinate to Premera allowable and do not accrue COB savings **(default on self-funded groups).**
- ❍ Non-duplication of benefits (if the primary plan pays less than the group plan would have paid if primary plan, the group plan pays the difference).

Appeal options. Select one.

- ❍ Premera provides levels I and II + Independent Review Organization (IRO.)
- ❍ Premera provides levels I and II – no IRO (grandfathered self-funded groups only).

Note: IRO fees will be billed to the group unless fiduciary services are purchased.

Will plan include extended inpatient benefits for terminating members (continue covering members confined in the hospital on the date coverage ends)? Select one.

- ❍ Yes
- ❍ No

Would you like to offer free credit monitoring through Experian to your members? Select one.

- ❍ Yes
- ❍ No

I. Legal and regulatory requirements

Helpful hint*:* We strongly urge you to consult legal counsel to answer the following questions. 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.

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.

- ❍ Yes. This plan will pay primary to Medicare as required by federal law.
- ❍ No. There are fewer than 20 employees.

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 is the primary payer for 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? Select one.

- ❍ 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. 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? Select one.

- ❍ Yes. This plan will be the primary payer to Medicare as required by federal law.
- ❍ No. There are under 100 employees.

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 Massachusetts (MA)? Select one.

- ❍ 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 the Employee Retirement Income Security Act (ERISA)? Select one.

- ❍ Yes. Complete the ERISA fields below.
- ❍ No. **Specify the legal reason for exemption. Select one.**
  - ❍ Government or public plan
  - ❍ Church plan
  - ❍ Other. Specify:

ERISA plan number	Month ERISA plan year ends	ERISA plan administrator

Helpful hint: 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 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 MM/DD/YYYY
Producer signature X_____	Producer of record (print name) Date signed MM/DD/YYYY / Producer number
Phone – include area code	Email address

Commission ☐ $ _____ PEPM ☐ _____ %

Split commission?

- ❍ Yes
- ❍ No

Commissions are split between the primary and secondary producer as follows:

Primary _____ % Secondary _____ %

Secondary producer agency	Effective date of appointment MM/DD/YYYY
Secondary producer name	Secondary producer number
Phone – include area code	Email address

K. Group agreement to contract

You, (the group named in section A 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 following:

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

Additionally, 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 start 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 health savings account (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 start 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:

- View benefit detail
- Inquire about eligibility
- Reinstate terminated members
- Inquire about or request invoices
- View group demographic information
- Order ID cards for an individual or whole family
- Search for members and enroll or cancel a member

Do you elect and authorize Premera Blue Cross to provide such information to the producer and their staff? Select one.

- ❍ Yes
- ❍ No

New non-grandfathered groups with a plan start 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 start date under the new Premera plan.

I affirm that this group is considered an employer under ERISA, is not considered a Multiple Employer Welfare Arrangement (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 Washington state, and I am authorized to sign on behalf of the group.

Signature	Group's representative (print name)	
X _____	Title	Date signed MM/DD/YYYY

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.