Self-Funded 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 50 characters and spaces, otherwise, optional.**)**			
Type of business:	Employer Identification Number (EIN):	SIC #:	NAICS #:
Physical address:			
City:	State:	ZIP code:	County:
Mailing address:			
City:	State:	ZIP code:	County:
Billing address (if different from mailing 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:			
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 you have more than six 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 you have more than six classes, attach additional class information.*

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)

Grandfathered plans – Would you like to waive the transplant waiting period?: ☐ Yes ☐ No

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

Newborn enrollment will follow the Erin Act: ☐ Yes ☐ No *The Washington Erin Act requires automatic newborn coverage for the first 21 days of life, if mother's pregnancy was covered under the plan.

Children covered due to legal guardianship effective: ☐ Date of guardianship order ☐ First of the month following order date

Foster children effective: ☐ Date of guardianship order ☐ First of the month following order date

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

Student and 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.*

Do you wish to extend the limiting age for covered children who are full-time students and age twenty-six (26) or over?
☐ Yes; limiting age is: _____ ☐ No

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: _____

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

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 _____	State/Country: _____ Number of employees: _____ 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 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 personal funding account products (HSA, HRA, FSA): ☐ Yes ☐ No , go to next section
Will your funding account products remain with the current vendor: ☐ Yes ☐ No If yes, vendor name:
Or will you move your HSA account administration to our vendor? ☐ Yes ☐ No If yes, list products:

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: _____
Group logo on booklets: ☐ Yes ☐ No
Will the group provide Premera plan-specific Summary Plan Description Information to be included in the benefit booklets (ERISA groups only)? ☐ Yes ☐ No

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 ☐ Paper ☐ **Name of 834 vendor if applicable:** _____
If paper, will you be using a custom member enrollment form: ☐ Yes ☐ No **If yes, please send a copy for Premera review**
Is common enrollment required: ☐ Yes ☐ No ☐ Not applicable ***Note:*** *Common enrollment means the employee has to enroll in each line of coverage (such as medical, dental, vision) offered through the group and any dependents enrolled under the employee will have to enroll in the same plans. This provision only applies to groups with medical plans offering standalone dental and/or vision plans. If you are 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**
Group logo on ID cards: ☐ Yes ☐ No

Billing setup

Claims payment method: ☐ Electronic fund transfer (EFT) pull by Premera ☐ Electronic fund transfer (EFT) push by group
Stop loss payment method: ☐ Electronic fund transfer (EFT) pull by Premera ☐ Electronic fund transfer (EFT) push by group ☐ Check
Administrative fee payment method: ☐ Electronic fund transfer (EFT) push through Premera employer portal ☐ Check
RX rebate delivery method (if electing to receive RX rebates): ☐ Electronic fund transfer to group ☐ Paper check mailed to group

Invoice and report distribution

Note: *Please list any group and producer representatives that would like to receive the invoices 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
		☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐

Include identifiable member names on the following monthly reports (make election):

8 Other provisions and administrative selections

Class action recovery:

☐ 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's 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:

☐ Coordinate to Premera's allowable plus accrue and pay COB savings for claims incurred in the same calendar year
☐ Coordinate to Premera's 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, the group plan pays the difference)

Appeal options: ☐ Premera provides levels I and II + 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.*

Include extended inpatient benefits (continue covering members confined in the hospital on the date coverage ends): ☐ Yes ☐ No

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

9 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, this plan is for less than 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, this plan is for less than 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:** _____

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

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: _____