Self-Funded Group Master Application

Grandfathered / Non-Grandfathered: 51+ enrolled employees

Application is made to Premera Blue Cross Blue Shield of Alaska (hereafter referred to as “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.

1 Account Information

Contract Period: To:	Renewal Month:	Group Number: (Completed by Premera)	
Legal employer name:			
Common employer name:(*Note: Required if legal name exceeds 50 characters and spaces, otherwise, optional.*)			
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 Alaska? ☐Yes ☐No If no, please contact your Sales Representative			
Is the group purchasing insurance under 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 under meeting the federal Controlled Group ownership requirement? ☐Yes ☐No			
Subsidiaries or affiliated companies (if applicable):			
Mailing Address:			
City:	State:	ZIP code:	County:
Group Benefit Administrator 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 Tax ID (if different than primary account)	Subgroup Billing and Mailing Contact Name (if different than primary account)	Subgroup Billing and Mailing Address (if different than primary account)
		Billing:	Billing:
		Mailing:	Mailing:
		Billing:	Billing:
		Mailing:	Mailing:
		Billing:	Billing:
		Mailing:	Mailing:
		Billing:	Billing:
		Mailing:	Mailing:

Note: *If more than 4 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	Plan(s) Available to Class	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 exceed exact 90 days. If more than 6 Classes, attach additional Class information.*

Eligibility Setup

Waive the probationary period for initial enrollment?

☐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)

Late enrollee process: ☐60 Days ☐Other: _____

Are retirees covered: ☐Yes ☐No

Would you like coverage to end the last day of the month? ☐Yes ☐Other: _____

Automatic newborn enrollment: ☐Yes ☐No

Grandchildren coverage: ☐Yes ☐No

Domestic partners: ☐Yes ☐No **If yes, offer COBRA rights of a spouse to Domestic Partners:** ☐Yes ☐No

3 Employee Enrollment Information

Total number of employees on payroll regardless of hours worked:	____________
Total number of employees eligible to enroll:	____________
Total number of eligible employees waiving enrollment without other coverage:	____________
Total number of eligible employees enrolling:	____________
Total number of retirees eligible for coverage:	____________
Total number of COBRA subscribers:	____________

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.*

	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:**
Will the prior carrier submit a deductible and out-of-pocket maximum balance report? ☐Yes ☐No **If no, individual member credit forms are available.**		
Name(s) of Dental carrier(s)being replaced:		**Effective date of coverage:** **Proposed termination date:**
Name(s) of Vision carrier(s) being replaced:		**Proposed termination date:**
Is Stop-Loss being replaced by Premera's Stop Loss vendor, LifeWise Assurance Company? ☐Yes ☐No **If No, please provide Stop-Loss Vendor name and contact.**		
Are you offering a plan or plans from a carrier other than Premera Blue Cross? ☐Yes ☐No, go to section 6		
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, DCFSA)? ☐Yes ☐No, go to section 7
Will your funding account products remain with the current vendor? ☐Yes ☐No If Yes, please provide vendor and customer service number

Will you move your personal funding account products administration to our vendor ConnectYourCare? ☐Yes ☐No If yes, list products: ______

7 Enrollment and Billing Process

Contracts and Benefit Booklets

Note: *Once approved, Benefit Booklets will be sent electronically and can be accessed online at premera.com*

Final contracts sent to: ☐Producer ☐Group Administrator ☐Other: ______ Contract signature is required within 90 days of effective date. Final contract will be sent electronically and can be accessed online at premera.com.	
Final contracts signed by:	**Email Address:**
Group logo on booklets: ☐Yes ☐No	**Group logo on ID Cards:** ☐Yes ☐No Member ID numbers will be provided as soon as initial enrollment has been processed. ID cards will arrive approximately 7-10 business days later.
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

Note: A Premera Enrollment spreadsheet will be provided for initial enrollment submission
Ongoing eligibility submitted via: ☐834 file from group (please allow for setup time) ☐ Premera's Enrollment Center (standard process if not using 834 file) **Name of 834 vendor if applicable:** __________ **Vendor's Contact Name:**_________________ **Vendor's Contact e-mail:** ___________________________
Is common enrollment required? ☐Yes ☐No ☐Not Applicable ***Note:*** *Common enrollment means the employee has to enroll in each line of coverage (i.e. 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 not offering standalone plans, this is not applicable.*

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	Include Member Names on Monthly Paid Claim Detail Report	Monthly Large Claim Report	Include Member Names on Monthly Large Claim Report	Monthly Stop Loss Invoice	Monthly Group Experience Report
		☐	☐	☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐	☐	☐

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.

Will plan include extended inpatient benefits for terminating members (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.
☐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).*

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.*

Month ERISA plan year ends: _____

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 Support Contact Primary:	
Phone Number:	**Email Address:**
Producer Support Contact Secondary:	
Phone Number:	**Email Address:**
Producer Signature:	
Medical Commission: ______________PEPM **Dental Commission**: _____________PEPM	
Split commission: ☐Yes ☐No **Secondary Medical Commission:** ______________PEPM **Secondary Dental Commission**: _____________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
- Confirmation of rates, plan designs, and all required documents

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 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.

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 listed producer support contacts? ☐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, has a physical location in the State of Alaska, 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.*