PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

3800 Centerpoint Drive, Suite 940
Anchorage, AK 99503-5825

Grandfathered / Non-grandfathered 51+enrolled employees

OptiFlex Employer Group Application

Application is made to Premera Blue Cross Blue Shield of Alaska (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. Group information

1.

Contract period MM/DD/YYYY
From date _____ To date _____

Renewal month

Legal name

Common employer name or doing business as (DBA) name (Required if legal name exceeds 43 characters and spaces)

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

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 physical address ❍ Separate address, complete below

Street/PO Box

City | State | ZIP code

4. **Is the group headquartered in Alaska?**
❍ Yes
❍ No. Contact your sales representative.

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

Is the group a subsidiary of or affiliated with another company meeting the federal controlled group ownership requirements? Select one.
❍ Yes
❍ No

	Subsidiaries or affiliated companies (if applicable)		
	Address		
	City	State	Zip Code
5.	Group contact name	Title	
	Phone – include area code	Email address	
6.	Billing contact name (if different from above)	Title	
	Phone – include area code	Email address	
7.	**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 A8. ❍ No ❍ No. Continue to section A9.		
8.	COBRA administrator name. This is the name of the company.		
	Street/PO Box		
	City	State	ZIP code
	COBRA contact name	Title	
	Phone – include area code	Email address	
9.	**Miscellaneous information**		
	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

1. Subgroup Setup

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

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

2. 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 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.

Class Description	Minimum Hours	Probationary Period Option 1	Probationary Period Option 2	Probationary Period Option 3
		❍ Exact date of hire	1st 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	1st 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	1st 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	1st 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	1st 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	1st of the month following: Select one. ❍ Date of hire ❍ 30 days ❍ 60 days ❍ Other _____	Next day following: Select one. ❍ 30 days ❍ 60 days ❍ Other _____

3. Eligibility Setup

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.

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

❍ Yes

❍ No. Specify other date:_____

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

❍ Marriage date

❍ First of the month following marriage

Does the plan cover domestic partners? Select one.

❍ Yes

❍ No

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

❍ Yes

❍ No

C. 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:	

D. Employer Contribution

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_____

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.

	Medical	Dental	Vision
Employee			
Spouse/Domestic Partner			
Dependent Child(ren)			
Dependent Spouse and Child(ren)			

E. Current Coverage Information

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

- ❍ Yes
- ❍ No

Name(s) of medical carrier(s) being replaced	Proposed end date MM/DD/YYYY
Name(s) of dental carrier(s) being replaced	Effective date of coverage MM/DD/YYYY
	Proposed end date 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 names 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 administration will remain with the current vendor.

If yes, provide vendor name: _____

❍ Funding account products administration will move to Premera's vendor.

If yes, list products: _____

❍ No. Continue to section G.

G. Group Materials and Enrollment

1. 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: _____

2. 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)

❍ Online via the Employer Administration Portal - SIMON

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 plans. If not offering standalone plans, this is not applicable.
- 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? Select one.

❍ 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/008813.pdf

H. 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.

1. **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.**

- ❍ 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 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).

2. **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.

3. **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 pay primary 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).

4. **Massachusetts (MA) 1099 Reporting**

Does the group have any employees that reside in the state of 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.

5. Is the group subject to Employee Retirement Income Security Act (ERISA)? Select one.

- ❍ Yes
- ❍ No. Specify the legal reason for exemption. Select one.
  - ❍ Government or public plan
  - ❍ Church plan
  - ❍ Other. Specify: _____

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 number	Month ERISA plan year ends	ERISA plan administrator

I. Other provisions and administrative selections

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

- ❍ Yes
- ❍ No

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	Start date of appointment MM/DD/YYYY	
Producer signature X _____	Producer of record (print name)	
	Date signed	Producer number
Phone – include area code	Email address	
Medical commission amount	PEPM	
Split commission? ❍ Yes ❍ No	Secondary medical commission per PEPM	
Secondary producer agency	Start 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 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 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 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:

- 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 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 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 Alaska, 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: 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.