PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Fully Insured Large Group Master Application (New Groups)

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. Requested Effective Date

2. Group Information

A. Legal Name

_____

Common Name (Required if Legal Name exceeds 43 characters and spaces)

_____

Physical Address _____

City _____ State _____ ZIP _____

B. Mailing Address ☐ Same as Physical Address ☐ Separate Address, complete the following:

Street/P.O. _____

City _____ State _____ ZIP _____

C. Billing Address ☐ Same as Mailing Address ☐ Separate Address, complete the following:

Street/P.O. _____

City _____ State _____ ZIP _____

Billing Contact _____

Phone No. (_____)_____-_____ Email _____

D. Employer Identification Number (EIN) _____

SIC # _____ NAICS # _____

E. Group Benefit Administrator Contact

_____

Phone No. (_____)_____-_____ Email _____

F. Subgroup Structure Does your group have a specific subset of membership that is to be allocated to a different billing location or entity?

☐ No, skip to Section G ☐ Yes, provide the following if different than above

1. Subgroup Name _____ Employer Identification Number (EIN) _____

Subgroup Billing Contact _____ Subgroup Benefit Contact _____

Mailing Address Street/P.O. _____

City _____ State _____ ZIP _____

Billing Address ☐ Same as Mailing Address

Street/P.O. _____

City _____ State _____ ZIP _____

2. Subgroup Name _____ Employer Identification Number (EIN) _____

Subgroup Billing Contact _____ Subgroup Benefit Contact _____

Mailing Address Street/P.O. _____

City _____ State _____ ZIP _____

Billing Address ☐ Same as Mailing Address

Street/P.O. _____

City _____ State _____ ZIP _____

3. Subgroup Name _____ Employer Identification Number (EIN) _____

Subgroup Billing Contact _____ Subgroup Benefit Contact _____

Mailing Address Street/P.O. _____

City _____ State _____ ZIP _____

Billing Address ☐ Same as Mailing Address

Street/P.O. _____

City _____ State _____ ZIP _____

4. Subgroup Name _____ Employer Identification Number (EIN) _____

Subgroup Billing Contact _____ Subgroup Benefit Contact _____

Mailing Address Street/P.O. _____

City _____ State _____ ZIP _____

Billing Address ☐ Same as Mailing Address

Street/P.O. _____

City _____ State _____ ZIP _____

G. If subject to COBRA, do you use a COBRA Administrator?

☐ No ☐ Yes, complete the following: ☐ Same as Billing Address and Contact Name

COBRA Administrator's Name

_____

Billing Address _____

City _____ State _____ ZIP _____

COBRA Administrator Billing Contact

_____

Phone No. (_____)_____-_____ Email _____

COBRA Administrator Benefit Contact

Phone No. (_____)_____-_____ Email _____

3. Group Eligibility

A large group employer is an employer who employed an average of at least 51 common law employees on business days during the preceding calendar year and who employs at least 51 common law employees on the first day of the current contract term. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a large group employer will be based on the average number of employees that it is reasonably expected to employ on business days in the current calendar year.

This count should include all full-time, part-time, seasonal, and union employees that work either inside or outside of the State of Alaska and employees worldwide from any affiliated company. Include business owners, corporate officers, and partners only if they are common-law employees. Contracted 1099 individuals should not be included. Common–law employees are defined under the Employee Retirement Income Security Act of 1974 (ERISA) and Internal Revenue Service (IRS) regulations, guidance, and case law. Consult with your legal counsel to ensure your employees are considered common-law employees under the law.

A.	Did the group employ an average of 51 or more employees during the previous calendar year?	☐ Yes	☐ No, contact your sales representative
B.	Is the group made up of multiple business/employers?	☐ Yes, complete B1	☐ No, skip to question E
1.	Are the businesses parent-subsidiary or brother-sister companies, meeting the federal Controlled Group ownership requirements?	☐ Yes, complete question C	☐ No, skip to question D
C.	Is the group a subsidiary of or affiliated with another company or headquartered outside the State of Alaska?	☐ Yes, complete questions C & D	☐ No, skip to question D

Legal Name _____

Physical Address _____

City _____ State _____ ZIP _____

D.	Does the large group qualify as an employer under 29 U.S.C Sec. 1002(5)?	☐ Yes	☐ No, contact your sales representative

Note: Multiple Employer Welfare Arrangements (MEWAs) and Associate Health Plan do not always qualify as an employer under 29 U.S.C Sec. 1002(f) (ERISA 3 (5). Only groups that qualify are eligible to purchase coverage as a large group.

E.	In the past 36 months has the group or any affiliated entity filed for protection or operated under federal/state bankruptcy laws?	☐ Yes	☐ No
F.	In the past 36 months has any creditor filed or threatened to file a petition requesting the group or any affiliated entity be put into bankruptcy?	☐ Yes	☐ No

G. Is worker's compensation coverage provided for all employees?

☐ Yes ☐ No, list employees not covered and reason: _____

4. Group Materials

A. Group Contract

A contract signature is required within 90 days of your plan effective date. The final contract will be sent electronically through DocuSign for an electronic signature to the contract signer listed below. Once signed, a copy can be downloaded and accessed through the secure employer website.

Group Authorized Contract Signer

Name _____ Email _____

B. Benefit Booklets

Copies of employee benefit booklets will be sent electronically and can be accessed online through the secure employer website.

Add group logo to benefit booklet? ☐ Yes (email logo to Premera Account Team) ☐ No

C. ID numbers/cards

Member ID numbers will be available as soon as initial enrollment has been processed. ID cards will arrive approximately 7 – 10 business days later. Members can also get their ID cards through the Premera mobile app.

Add group logo to ID cards? ☐ Yes (email logo to Premera Account Team) ☐ No

D. Enrollment Method

Note: A Premera enrollment spreadsheet will be provided for initial enrollment submission.

Ongoing eligibility submitted via: ☐ Electronic eligibility file (please allow for set-up time) ☐ Premera's Enrollment Center (standard process if not using an electronic eligibility file)

Vendor's Name: _____ Vendor's Analyst Contact Name: _____

Phone Number: (_____)_____-_____ Email: _____

5. Current Coverage Information

A. Is this plan intended to replace any existing coverage? ☐ No, skip to Section 6 ☐ Yes

Name(s) of prior Medical carrier(s)	Name(s) of prior Dental carrier(s)	Name(s) of prior Vision carrier(s)
_____	_____	_____
Termination date _____	Termination date _____	Termination date _____

B. Are you offering a plan from a carrier other than Premera Blue Cross Blue Shield of Alaska?

☐ No, skip to Section 6 ☐ Yes, more than one carrier's plan is offered:

Name(s) of other Medical carrier(s)

Indicate if other plan is a High Deductible Health Plan (HDHP)	HDHP?	**Name(s) of other Dental carrier(s)**	**Name(s) of other Vision carrier(s)**
_____	☐ No ☐ Yes	_____	_____
_____	☐ No ☐ Yes	_____	_____
_____	☐ No ☐ Yes	_____	_____

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.

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

☐ No ☐ Yes, provide the Vendor Name: _____

D. Will you be using our personal funding account vendor, for your personal funding account administration? ☐ No ☐ Yes

6. Employee Eligibility Requirements

If all of your employees must work the same hours, meet the same probationary period, and will have the same benefits options available to them, complete Section A (omit B), then continue to C, D, and E.

If you are differentiating your employees by class (such as managers, hourly workers) complete Section B (skip A), then continue to C, D, E, and F.

A. All Employees in One Class

1. All employees who normally work a minimum of _____ hours* per week and have satisfied the probationary period are eligible.

***Note:** 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.

2. Probationary Period Information

All eligible employees are effective on the:

☐ 1st of the month following: ☐ Next day following: ☐ Exact date of hire

☐ Date of hire

☐ 30 days ☐ 30 days

☐ 60 days ☐ 60 days

☐ ____ Number of days from (enter date) * _____ ☐ ____ Number of days from (enter date) * _____

***Note**: Probationary period cannot exceed exact 90 days.

B. Employees Differentiated by Class

Minimum Work Hours and Probationary Period Information

Complete the minimum work hours* and probationary period information for each designated class of employee.

***Note:** 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	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 ________

C. Waive Probationary Period

☐ Waive the probationary period on all current qualifying employees.

☐ Apply the probationary period to all employees (current qualifying employees must satisfy the probationary period).

D. Coverage will end

☐ Last day of the month for which subscription charge is paid

☐ Other _____

E. Will domestic partners be eligible for coverage? ☐ No ☐ Yes

Will domestic partners be eligible for COBRA? ☐ No ☐ Yes

F. Common Enrollment? ☐ No ☐ Yes

(Any dependents must enroll in the same plan as the employee/subscriber offered by the group. This only applies to groups with Premera medical plans offering standalone Premera dental plans.)

7. Employee Enrollment

A. Total number of employees on payroll regardless of hours worked _____

Note: Count each employee in only one category.

B. Total number of employees not eligible to enroll _____

Employees working less than the minimum number of hours per week, in probationary period, temporary or seasonal, or not in a covered class _____

C. Total number of employees not enrolling due to other coverage _____

D. Total number of employees eligible to enroll (sections A – B – C) _____

E. Total number of eligible employees waiving enrollment without other coverage _____

F. Estimated number of eligible employees enrolling (sections D – E) _____

Calculate employee participation by dividing eligible employees enrolling (F) by the total number of employees waiving without other coverage (E) _____
Participation percentages under 75% require underwriting approval.

G. Total number of retirees eligible for benefits _____

H. Total number of COBRA subscribers _____

I. Do you have eligible employees employed outside the state of Alaska? ☐ No ☐ Yes, complete the table below

State/Country	Number of Employees

8. Employer Contribution Requirements

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

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

9. Federal Requirements

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 that would cause the group's answers below to change.

A. 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?

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

2. Please also provide the number of employees who now meet Medicare's definition of "employee." _____

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.

"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).

B. Is the group subject to COBRA?

☐ Yes ☐ No. Give the legal reason for exemption _____

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 §401has (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.

C. 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?

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

2. Please also provide the number of employees who now meet Medicare's definition of "employee." _____

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. See the helpful hint in 6 above for a definition of "employee" for this purpose.

D. Is the group subject to ERISA (Employee Retirement Income Security Act)?

☐ Yes. Enter the month the ERISA plan year ends Month _____

☐ No. Give the legal reason for exemption ☐ Government or public plan ☐ Church plan

☐ Other, please specify _____

Generally, ERISA applies to all employer health plans except governmental, public, or church plans. Nonprofit status alone does not exempt an employer from ERISA.

10. Producer Agreement to Contract

A. Producer of record name	Producer Number
Phone Number	Email
Name of Firm/Agency	

Medical Commission	☐ _____ PEPM	☐ _____ %
Dental Commission	☐ _____ PEPM	☐ _____ %

B. Producer Support Contact(s)

Contact Name (print name)	Contact Name (print name)
Email	Email
Phone Number:	Phone Number:

C. ☐ **Split Commission**

Secondary Producer Name | Secondary Producer Number

Commissions are split between the primary and secondary producer as follows: Primary: ___% Secondary: ___%

You, the Producer, 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 Signature _____ Date ___/___/_____ (mm/dd/yyyy)

Producer (print name) _____

11. Group Agreement to Contract

You, the group named in Section 2 of this application, understand and agree to the following.

A. This application becomes part of the contract to provide healthcare coverage after:

- The application is signed by you;
- The application is received and approved by us; and
- We receive the initial month's subscription charges.

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 the plan's special enrollment rights to all eligible employees before their enrollment. You attest to have read this application and represent that all statements are true and complete.

You agree to the terms and obligations stated in this application. It is understood that provisions of the Health Care Contract, including subscription charges, may be amended, or changed from time to time, upon our notice to you. 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 producer agreement to contract section 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 should 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 employees' reimbursement of claims activities incurred prior to the has 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.

B. Do you elect and authorize Premera Blue Cross Blue Shield of Alaska to provide such information to the producer and producer support staff? (Is the Producer authorized as group administrator?) ☐ No ☐ Yes

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 by calling Premera.

These functions may include, but are not limited to:

- Reinstate Terminated Members
- Inquire on Invoice
- Order ID Cards for an individual or Whole Family
- Request Invoice
- Inquire on Eligibility
- View Group Demographic Information
- Search for a Member
- Enroll a Member
- Cancel a Member
- View Benefit Detail

C. I affirm that this group is eligible to purchase coverage as a large employer under state and federal law and has a physical location in the State of Alaska, and I am authorized to sign on behalf of the group.

Signature of Group's Representative

Date ___/___/_____ (mm/dd/yyyy)

Group's Representative (print name)

Title _____

Please 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.