Regence

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueCross BlueShield of Oregon
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Group Master Application for Administrative Services Contract

(For Grandfathered Groups Only)

This Group Master Application for Administrative Services Contract (GMA-ASC) collects information necessary to the preparation of a binding Administrative Services Contract (ASC) between Regence BlueCross BlueShield of Oregon (Regence) and the following Plan Sponsor and Group Health Plan. The resulting ASC will describe the administrative services to be provided by Regence, the terms and conditions of their provision, and the respective responsibilities of each of the parties. Once executed by all parties, the ASC will prevail in the event of any conflict between its terms, conditions, and content and any information provided on, or provision of, this GMA-ASC or any term, condition, or element of the sample ASC affixed to this GMA-ASC.

This GMA-ASC also provides information for Regence's use in commencing the programming and the system and process design related to the contemplated administration of the Group Health Plan.

Requested Effective Date _____

SECTION 1 - GROUP INFORMATION

Group Health Plan Name		Group Number
Employer Legal Name (Plan Sponsor)	Doing Business As (DBA)	Name to be used by Regence ☐ Legal ☐ DBA
Employer Federal (EIN) and State (if applicable) Tax ID Numbers		Location of Business Headquarters
SIC Code and Industry Description		Company Structure ☐ Sole Proprietorship ☐ Corporation ☐ Partnership ☐ Other _____
Name and Title of President, Owner, CEO		Group's Primary Language (if other than English)
Physical Business Address **Required** (No PO Box or PMB)		Mailing Address (if different from Physical Business Address)
City, State and ZIP Code		City, State and ZIP Code
County	Phone Number ( ) Fax Number ( )	County / Phone Number ( ) Fax Number ( )

PRIMARY GROUP CONTACT

Name (First, MI, Last)		Title
Phone Number ( )	Fax Number ( )	E-mail Address

PLAN ADMINISTRATOR (if different from primary contact)

Name (First, MI, Last) or Name of Commitee or Board		Title
Phone Number ( )	Fax Number ( )	E-mail Address

SECTION 1 - GROUP INFORMATION (continued)

PLAN INFORMATION

Medical:
Does your group have a current plan providing medical benefits? ☐ No ☐ Yes
If yes, is the plan insured or self-insured? ☐ Insured ☐ Self-insured
Name of carrier _____
Date coverage will end _____

Workers' Compensation:
Does your group have Workers' Compensation coverage?
☐ No ☐ Yes
If yes, name of carrier _____

Pharmacy:
Does your group have a current plan providing pharmacy benefits? ☐ No ☐ Yes
If yes, is the plan insured or self-insured? ☐ Insured ☐ Self-insured
Name of carrier _____
Date coverage will end _____

Dental:
Does your group have a current plan providing dental benefits? ☐ No ☐ Yes
If yes, is the plan insured or self-insured? ☐ Insured ☐ Self-insured
Name of carrier _____
Date coverage will end _____

Will you be offering more than one medical option to your employees? ☐ No ☐ Yes *
If so and if any of your plan is insured, name(s) of carrier(s)
_____
*** This option is not allowed in all instances.**

Will you be offering more than one dental option to your employees? ☐ No ☐ Yes *
If so and if any of your plan is insured, name(s) of carrier(s)
_____
*** This option is not allowed in all instances.**

SECTION 1 - GROUP INFORMATION (continued)

BILLING - ADMINISTRATIVE

Do you require separate billing invoices? ☐ No ☐ Yes **(If yes, please complete Additional Billing section(s) below)**

Business Name	**Additional Billing** Business Name	**Additional Billing** Business Name
Billing Address	Billing Address	Billing Address
City, State and ZIP Code	City, State and ZIP Code	City, State and ZIP Code
Phone Number ( )	Phone Number ( )	Phone Number ( )
Fax Number ( )	Fax Number ( )	Fax Number ( )
Contact and Title (if different than primary group contact)	Contact and Title (if different than primary group contact)	Contact and Title (if different than primary group contact)
Payment Type	**Payment Type**	**Payment Type**
☐ Pay by Check ☐ Wire Transfer ☐ SurePay(EFT) - Please submit Surepay document	☐ Pay by Check ☐ Wire Transfer ☐ SurePay(EFT) - Please submit Surepay document	☐ Pay by Check ☐ Wire Transfer ☐ SurePay(EFT) - Please submit Surepay document

BILLING - CLAIMS

Do you require separate billing invoices? ☐ No ☐ Yes **(If yes, please complete Additional Billing section(s) below)**

Type of Invoice: ☐ Summary ☐ Detail Hardcopy requested? ☐ No ☐ Yes

Business Name	**Additional Billing** Business Name	**Additional Billing** Business Name
Billing Address	Billing Address	Billing Address
City, State and ZIP Code	City, State and ZIP Code	City, State and ZIP Code
Phone Number ( )	Phone Number ( )	Phone Number ( )
Fax Number ( )	Fax Number ( )	Fax Number ( )
Contact and Title (if different than primary group contact)	Contact and Title (if different than primary group contact)	Contact and Title (if different than primary group contact)
Payment Type	**Payment Type**	**Payment Type**
☐ Wire Transfer ☐ Weekly ☐ Monthly	☐ Wire Transfer ☐ Weekly ☐ Monthly	☐ Wire Transfer ☐ Weekly ☐ Monthly

SECTION 1 - GROUP INFORMATION (continued)

EMPLOYER CENTER

Employer Based Reporting ☐ No ☐ Yes* Online Enrollment and eBilling ☐ No ☐ Yes*

***Primary Group Administrator for Employer Center:** Name (First, MI, Last)	E-mail Address	Phone Number ( )

If more than two Secondary Group Administrators for Employer Center are required, indicate the number desired _____

For Online Enrollment, complete the following:

Allow employees to enroll themselves and update family information online ☐ No ☐ Yes

If Yes, allow employees to change their address online ☐ No ☐ Yes

How does the group want employer reporting broken out by (i.e. locations, classes, sections, etc.)?

FEDERAL MANDATES

COBRA:

Group subject to COBRA? ☐ No ☐ Yes

COBRA applies to employer groups that have employed 20 or more employees for 50% or more of the typical business days in the preceding calendar year (January - December), with the exception of federal government plans and church plans. To the degree permitted by those laws, part-time employees may be counted as a fraction of a full-time employee.

OBRA:

Group subject to OBRA? ☐ No ☐ Yes

If you employed 100 or more full-time and/or part-time employees for at least 50% of the workdays of the preceding calendar year (January - December) you are subject to federal OBRA 1989/OBRA 1993 laws.

TEFRA/DEFRA:

Group subject to TEFRA/DEFRA? ☐ No ☐ Yes

If you employed 20 or more full-time and/or part-time employees during each of 20 calendar weeks in the current or preceding calendar year (January - December) you are subject to federal TEFRA/DEFRA laws.

ERISA:

Group subject to ERISA? ☐ No ☐ Yes

Is your plan year different than your renewal date? ☐ No ☐ Yes, list date _____

Virtually all health plans of employers of any size (except church entities and government entities) are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA). This federal law sets minimum standards for the protection of individuals covered by a health plan subject to ERISA, as well as most voluntarily established pension plans.

ERISA Plan Note: If you use the benefit booklet as a component of the summary plan description and want to investigate meeting your distribution requirement electronically, see 29 CFR §2520.104b-1(c) for the U.S. Department of Labor's electronic distribution safe harbor.

Schedule A / Form 5500 information required?

☐ No ☐ Yes If yes, reporting time frame required _____

Schedule C information required?

☐ No ☐ Yes If yes, reporting time frame required _____

SECTION 1 - GROUP INFORMATION (continued)

AGENT INFORMATION

Agency Name	Agent (Producer) Name	
Agent E-mail Address	Agent Phone Number	Agent Number
Secondary Agent Name	Secondary Agent Phone Number	Secondary Agent Number

Agent Medical and/or Pharmacy Commission:

☐ PEPM $_____ ☐ PMPM $_____ ☐ None

Commission Split %:

Agent #1 _____ % Agent #2 _____ %

Agent Dental Commission:

☐ PEPM $_____ ☐ PMPM $_____ ☐ None

Commission Split %:

Agent #1 _____ % Agent #2 _____ %

Additional Information:

SECTION 2 - ELIGIBILITY INFORMATION

GROUP ELIGIBILITY (for purposes of determining group classification)

Note: An "eligible employee" is defined as an employee who on a full-time basis worked 17.5 or more hours per week.

1. Average number of employees in the preceding calendar year _____
2. Current number of eligible employees _____
3. Do you have eligible employees employed outside the State? ☐ No ☐ Yes If yes, please indicate below

   Note: Group members who reside in the state of Hawaii are not eligible for coverage.
4. Do you file consolidated taxes? ☐ No ☐ Yes

   If yes, please explain _____

Number of Employees Out of State	State 1	State 2	State 3	State 4	State 5	State 6
State						
Employee Count						

EMPLOYEE ELIGIBILITY (for purposes of determining who is eligible for group benefits)

Note: The employer may determine the hours worked for eligibility between 17.5 and 40 hours/week.

1. This plan covers employees working the minimum number of hours required for coverage.

   The minimum number of hours to be eligible for coverage are _____

2A. This plan covers the following: ☐ Employees and Dependents (incl. Oregon-Certified Domestic Partners)
☐ Employee Only **(No dependent coverage)**

2B. This plan provides domestic partner coverage: ☐ No ☐ Yes

3. Probationary Periods:

Groups may list employees in different classifications (e.g. hourly, salaried) for the purpose of offering different probationary periods to each employee classification. If you have chosen to do this, describe each job classification below. **All employees must be accounted for.** (If there are no classes, please enter all information in space provided for Class 1).

	Actual Date of Hire	**Coverage is effective on the first of the month following** (please place an X in the appropriate box below)							
		Date of Hire (see 3A below)*	30 Days	60 Days	90 Days	120 Days	180 Days	365 Days	Other
Class 1:									
Class 2:									
Class 3:									

Additional Comments _____

3A. *Choose how Date of Hire (DOH) Probationary Period will be administered:
☐ Effective date will always be 1st of the month following DOH, even if DOH is the 1st of the month.
☐ Effective date will be 1st of the month following DOH, with the exception of when the DOH is the 1st of the month.

3B. Is probationary period waived on group's initial enrollment: ☐ No ☐ Yes

3C. For employees transferring from part-time to full-time status, the probationary period specified above should apply:
☐ Beginning on the date transferred to full-time status ☐ Retroactive to the original date of hire

SECTION 3 - EMPLOYER CONTRIBUTION

The employer will pay the following percentages/dollars toward the monthly rate. If different classes are chosen, please indicate classes and contribution for each.

Note: Employer must contribute a minimum of 50% of the employee rate for insurance. There is no minimum employer contribution percentage for dependents.

	Class 1		Class 2		Class 3	
	Medical and/or Pharmacy	Dental	Medical and/or Pharmacy	Dental	Medical and/or Pharmacy	Dental
Employee	% or $	% or $	% or $	% or $	% or $	% or $
Dependent	% or $	% or $	% or $	% or $	% or $	% or $

SECTION 4 - GROUP PARTICIPATION

Note: There is a minimum participation requirement of 75% (not counting waivers for other qualifying coverage).

	Medical	Dental
1. Total number of employees on payroll regardless of hours worked (Do not include COBRA participants)		
2. Less individuals not eligible for coverage on this plan:		
a) Employees working fewer than the minimum hours described in Section 2 Eligibility Information including those who are part-time.	–	
b) Employees who are temporary, seasonal or substitute employees.	–	
c) Employees who are fulfilling their New Hire Probationary Period described in Section 2 Eligibility Information.	–	
d) Individuals paid via IRS Form 1099.	–	
3. Equals subtotal number of employees eligible to enroll.		=
4. Less number of employees waiving for **other qualifying coverage.**	–	–
5. Equals total number of employees eligible to enroll.	=	=
6. Number of employees who are **declining coverage. (No other qualifying coverage).**		
7. Number of employee applications being submitted (for new groups only).		
8. Number of former and current employees covered by your group under COBRA.		
9. Number of former and current employees and/or their dependents who are currently eligible for COBRA but have not yet applied.		
10. Number of former and current employees not eligible for COBRA who are covered by a group extension plan.		

SECTION 5 - ACKNOWLEDGMENTS AND CERTIFICATIONS

I am duly authorized to complete and submit this GMA-ASC on behalf of the Group Health Plan and/or Plan Sponsor as indicated below, and all statements made and information provided herein are accurate and complete to the best of my knowledge and belief. I acknowledge that Regence will rely in part upon the information in this GMA-ASC as the basis for its decision whether to enter the contemplated administrative services arrangement, will rely upon it to begin preparations for providing the service of that arrangement, and, if an ASC has not been finalized by the Requested Effective Date hereof, may rely upon it to begin providing administrative services as described below. If any of the information provided in this ASC should change before the finalization of the ASC with Regence, I agree to provide that updated information to Regence promptly after the change. Further, on behalf of the Group Health Plan and/or Plan Sponsor, I:

a) Acknowledge that eligibility standards (e.g., waiting period, minimum hours, etc.) must be established at the time of initial application, may be changed only at contract renewal, and must be adhered to for all employees and dependents.

b) Agree to make payroll and other records directly related to employee participation levels or to employees' coverage, premiums, or contributions under the group contract(s) available to Regence for inspection. This provision shall survive the termination of the group contract(s). Upon renewal or anytime throughout the contract period, the Company agrees to provide Regence, upon its request, verifications of employee participation levels.

c) Agree that, except with regard to a statutory continuation of coverage or unless the change is approved in writing by an authorized representative of Regence, at no time shall any employee be permitted or required to make contributions for coverage at a rate higher than the employee contribution rate represented herein.

d) Appoint the agent of record indicated in Section 1 - Group Information (if any) to represent it in matters of group coverage benefits provided by Regence. This appointment is in effect on the same day as the group coverage(s) and remains in force until rescinded in writing.

e) Acknowledge that, if the Company has an agent, that agent may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation from Regence. Incentives may be based on any of several factors, including the size of the Company's business, the products that the Company purchases, the agent's volume of business with Regence, and other services the agent provides to the Company. These incentives may have an indirect impact on the Company's rates. For more information, please contact the agent for the Company.

I agree that, if an ASC has not been fully executed before the Requested Effective Date specified herein, Regence may choose (by providing written notice to Plan Sponsor and Group Health Plan, and unless Plan Sponsor and/or Group Health Plan decline in writing within 3 days of such notice) to regard this GMA-ASC as an agreement in principle and to begin administration in accordance with the information provided in this GMA-ASC and, except as described below, in accordance with the terms, conditions, and other elements of the sample ASC affixed hereto until a fully executed ASC has been finalized by the parties. During any such period that Regence provides administration before finalization of ASC:

a) Regence will administer the benefits described in this GMA-ASC and, in the event of conflict, those benefits shall take precedence over the benefits described in the Group Health Plan's most current summary plan description or benefit booklet (whether or not that summary plan description or benefit booklet has been provided to Regence);

b) Plan Sponsor will pay Regence the administrative and other fees set forth in the attached fee schedule and those fees may be adjusted for any of the reasons set out in the sample ASC;

c) Plan Sponsor will pay Regence the amount of each Weekly Claims Call within two (2) days of Regence's communication of the amount owed;

d) Regence will not provide any nonstandard reports to Plan Sponsor or Group Health Plan;

e) The fixed percentage of subrogation and right of reimbursement recoveries withheld by Regence to cover its costs of pursuit will be thirty percent (30%);

SECTION 5 - ACKNOWLEDGMENTS AND CERTIFICATIONS (continued)

f) The late fee for administrative fees, claims or other invoices that are not paid to Regence by the due date will be 3% per month;

g) Plan Sponsor and Group Health Plan will have no audit rights referenced in the sample ASC;

h) Regence will not provide Run-out Claims Processing for the Group Health Plan if the negotiations for an ASC are terminated without an ASC being executed; and

i) Regence may cease providing administration at anytime before ASC is executed.

In the event that Regence does commence providing administrative services before the parties finalize the ASC, Regence will have no obligation upon finalization of the ASC to revise or modify the services that it has already provided, except as expressly agreed in writing among the parties.

WE'VE GONE GREEN! To be more environmentally conscious and in response to employer requests, we will attach one paper copy of the booklet (unless another quantity has been previously arranged) describing your plans benefits to your contract. Inform your plan participants that they can access the booklet electronically at myRegence.com. Or, if preferred, you can contact your sales representative to order additional paper copies for distribution or can have any requesting plan participant request a paper copy by contacting customer service.

SIGNATURES

GROUP HEALTH PLAN

Authorized Signature ▶ _____

Title ▶ _____

Date ▶ _____

PLAN SPONSOR

Authorized Signature ▶ _____

Title ▶ _____

Date ▶ _____