Regence

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

Regence BlueCross BlueShield of Utah
2890 E. Cottonwood Parkway
PO Box 30270
Salt Lake City, Utah 84130-0270

Group Master Application for Administrative Services Contract

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 Utah (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 A - 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)	
County	Phone Number ( ) Fax Number ( )	County	Phone Number ( ) Fax Number ( )

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

SECTION A - GROUP INFORMATION (continued)

BILLING - ADMINISTRATIVE

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

Billing Name to be used by Regence ☐ Legal ☐ DBA	Contact and Title (if different than plan administrator)
Billing Address (include Attention line if applicable)	Phone Number ( ) Fax Number ( )

Payment Type: ☐ Pay by Check ☐ Wire Transfer ☐ Surepay (EFT) **Please submit Surepay document**

Additional Billing Name to be used by Regence	Contact and Title (if different than plan administrator)
Billing Address (include Attention line if applicable)	Phone Number ( ) Fax Number ( )

Payment Type: ☐ Pay by Check ☐ Wire Transfer ☐ Surepay (EFT) **Please submit Surepay document**

BILLING - CLAIMS

Business Name	Contact and Title (if different than plan administrator)
Billing Address	Phone Number ( ) Fax Number ( )

Payment Type

☐ Weekly ACH Pull (preferred) ☐ Weekly Wire Transfer ☐ Monthly ACH Pull ☐ Monthly Wire Transfer

If selecting an ACH payment option please complete and submit an Authorization Agreement for Electronic Remittance with this GMA.

ENROLLMENT METHOD AND EMPLOYER CENTER

Enrollment Method

Please indicate your enrollment method by checking the desired option from the listing below.	**Initial or Open Enrollment** with Regence	**Ongoing Enrollment** with Regence
Spreadsheet **Note: Only available for Initial Enrollment**	☐	
Regence Online Enrollment When selecting Regence Online Enrollment, would you like to allow your employees to enroll themselves? ☐ No ☐ Yes **Regence Marketplace** Would your group like to use the online Regence Marketplace? ☐ No ☐ Yes What is the annual Defined Contribution amount for your employees?_____ (If amount depends on employee class, please submit on separate page)	☐	☐
ANSI 834	☐	☐
Paper Enrollment Forms	☐	☐

Employer Center

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

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

Employer Based Reporting: ☐ No ☐ Yes

How does the group want employer reporting broken out (by Billing Location as outlined in Section A - Group Information; or by Class as outlined in Section F - Employee Eligibility?)

SECTION B - PRODUCER (AGENT) INFORMATION

Agency Name	Producer's E-mail Address	
Producer's Name	Producer's Phone Number	Producer's Number
Secondary Producer's Name	Secondary Producer's Phone Number	Secondary Producer's Number

Producer's Medical and/or Pharmacy Commission:

☐PEPM $_____ ☐PMPM $_____ ☐None

Commission Split %:

Producer #1 _____ % Producer #2 _____ %

Producer's Dental Commission:

☐PEPM $_____ ☐PMPM $_____ ☐None

Commission Split %:

Producer #1 _____ % Producer #2 _____ %

Additional Information:

SECTION C - 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.

**If you are subject to COBRA, do you utilize a COBRA third party administrator (TPA)? ☐No ☐Yes

If yes, who is your COBRA administrator _____

Please indicate if your COBRA TPA is providing any of these services by checking the appropriate box(es).

☐ Regence billing sent directly to the TPA for COBRA participants. (Be sure to complete the additional billing information above in Section A for this TPA.)

☐ TPA submits COBRA Enrollment and Dis-Enrollment directly to Regence.

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 the TEFRA/DEFRA status has changed within the past year, please indicate the Date of Change _____

If you employed 20 or more full-time and/or part-time employees for each working day in each of 20 or more 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

If 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 & C / 5500:

Per section 104 of ERISA, your group may be required to file IRS Form 5500 (Schedule A & C).

Do you require information from us to help you complete your Schedule A & C / Form 5500? ☐No ☐Yes

If yes, this information will be provided based on your insurance contract period.

SECTION D - OTHER CARRIER INFORMATION

1. Does your group have current medical/dental/pharmacy benefits?

Medical: ☐ No ☐ Yes If yes, name of carrier _____ End date _____
If yes, is the plan insured or self-insured? ☐ Insured ☐ Self-insured

Dental: ☐ No ☐ Yes If yes, name of carrier _____ End date _____
If yes, is the plan insured or self-insured? ☐ Insured ☐ Self-insured

Pharmacy: ☐ No ☐ Yes If yes, name of carrier _____ End date _____
If yes, is the plan insured or self-insured? ☐ Insured ☐ Self-insured

2. Will you be offering more than one medical/dental carrier to your employees?

Medical: ☐ No ☐ Yes* If so and if any of your plan is insured, name of carrier(s) _____

Dental: ☐ No ☐ Yes* If so and if any of your plan is insured, name of carrier(s) _____

***This option is not allowed in all instances.**

3. Does your group have Workers' Compensation coverage?

☐ No ☐ Yes If yes, name of carrier _____

SECTION E - GROUP ELIGIBILITY (for purposes of determining group classification)

Note: An "eligible employee" is defined as an employee who on a full-time basis worked 30 or more hours/week in the preceding calendar year.

1. Number of eligible employees in the preceding calendar year _____
2. Is the group affiliated with any other company (parent, subsidiary or other entity)? ☐ No ☐ Yes

   If yes, please explain _____
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.

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

SECTION F - EMPLOYEE AND DEPENDENT ELIGIBILITY (for determining who is eligible for group benefits)

Note: The minimum number of hours worked for eligibility are 30 hours in a normal work 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 _____

2. This plan covers the following options: (check all that apply)	Medical/ Pharmacy/ Vision	Dental
Employee and Dependent (legal spouse or eligible domestic partner and children)	☐	☐
When offering Employee and Dependent coverage this plan provides for: ☐ Eligible spouses include only opposite sex spouses ☐ Domestic Partner ☐ No Domestic Partner Coverage		
Employee Only (No dependent coverage)	☐	☐
Employee and Children Only (No spouse or domestic partner)	☐	

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).

	Please place an X in the appropriate box below						
	Coverage is effective on the actual				**Coverage is effective on the first of the month following**		
	Date of Hire	30th Day	60th Day	90th Day	Date of Hire (see 3A below)*	30 Days	60 Days
Class 1:							
Class 2:							
Class 3:							

Additional Comments _____

3A. *If Date of Hire (DOH) option is selected above, choose how 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

Note: Effective September 23, 2010, federal health reform prohibited employers from discrimination in favor of highly compensated individuals set forth in Internal Revenue Code section 105(h). Enforcement of this prohibition has been delayed until associated regulations or other guidance has been issued and it is unclear when that may occur. Regence is unable to determine whether a plan discriminates in a way that violates the federal reform provisions, both because guidance has not been issued and because it does not have access to information necessary to identify highly compensated individuals. Because this element of federal reform is intended to fine employers with discriminatory plans, Regence recommends that employers obtain tax and/or legal advice associated with maintaining any plan provision that may prove discriminatory.

SECTION G - EMPLOYER CONTRIBUTION

New groups may enroll without meeting a minimum employer contribution or group participation percentage. *~~Please note~~, however, that groups may not be renewed if they fail to meet either (or both) of the following contribution or participation standards at the time of their renewal.*

Employer Contribution Level: There is a minimum employer contribution percentage of 75% towards the employee coverage and no minimum employer contribution percentage for dependents **or** the employer contribution may equate to at minimum 50% of the total cost of premium. Using the table below, please indicate whether the Employer Contribution is based by product (e.g., BluePoint, HSA Healthplan 3.0, etc.) or by class (e.g. hourly/salary etc.) and enter the percentage amount **or** dollar amount that the employer will pay towards the monthly rate of the elected coverage type (medical/dental).

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

☐ By Product	Option 1, specify product _____		Option 2, specify product _____		Option 3, specify product _____	
☐ By Class	Class 1		Class 2		Class 3	
Coverage Type	Medical/ Pharmacy/Vision	Dental	Medical/ Pharmacy/Vision	Dental	Medical/ Pharmacy/Vision	Dental
Employee	% or $	% or $	% or $	% or $	% or $	% or $
Dependent	% or $	% or $	% or $	% or $	% or $	% or $

SECTION H - GROUP PARTICIPATION

Participation Requirements: There is a minimum participation requirement of 75% of eligible employees (line 5 below) after consideration of valid waivers and at least 50% of the total eligible employees (line 3) must participate.

1. Total number of employees on payroll regardless of hours worked (Do not include individuals participating on COBRA). + _____
2. Less individuals not eligible for coverage on this plan (account for each of these individuals in one of the following that best applies):
   a) Number of employees working fewer than the minimum hours (as selected in Section F - Employee Eligibility). – _____
   b) Number of employees who are fulfilling their New Hire Probationary Period (as selected in Section F - Employee Eligibility). – _____
   c) Number of employees who are seasonal, substitute or temporary. – _____
   d) Number of individuals who are paid solely via IRS Form 1099. – _____
   e) Number of employees whose class is ineligible for coverage under this plan. Please enter the description of your group's ineligible class _____ , if union, please provide a copy of the union roster – _____
3. Equals sub-total number of employees eligible to enroll. = _____

Using the number of employees eligible to enroll (from line 3 above), continue for each type of coverage (Medical/Dental) elected:	Medical	Dental
4. Less number of employees who are waiving for **other qualifying coverage.**	–	–
5. Equals total number of employees eligible to enroll.	=	=
6. Less number of employees who are **declining coverage. (No other qualifying coverage).**	–	–
7. Equals number of employee applications submitted **(new groups)** / number of employees on coverage on the effective date **(renewing groups)**.	=	=
8. Employees participation percentage (line 7 divided by line 5).	%	%
9. Number of subscribers and/or their dependents covered by your group under COBRA.		
10. Number of former and current employees and/or their dependents who are currently eligible for COBRA but have not yet applied.		

SECTION I - 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 B - Producer (Agent) 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 I - 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.

Any accompanying foreign language version of this form is provided only as an accommodation or courtesy to the customer and this English language version shall control the resolution of any dispute or complaint.

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 Regence.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 ▶ _____

Print Authorized Name ▶ _____

Official Title ▶ _____

Signature Date ▶ _____

PLAN SPONSOR

Authorized Signature ▶ _____

Print Authorized Name ▶ _____

Official Title ▶ _____

Signature Date ▶ _____