



<b>For Internal Use Only</b> Effective Date _____ Group Number _____
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## RENEWAL Employer Participation Agreement

### EMPLOYER INFORMATION

Legal Name of Employer \_\_\_\_\_ President/CEO \_\_\_\_\_  
 Employer Contact Name \_\_\_\_\_ Phone \_\_\_\_\_ Ext \_\_\_\_\_  
 Email \_\_\_\_\_ Fax \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
 County \_\_\_\_\_ Tax Identification Number (TIN) \_\_\_\_\_  
 Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
 Legal Status: \_\_\_ Proprietorship \_\_\_ Partnership \_\_\_ Corporation \_\_\_ Government Entity \_\_\_ LLC \_\_\_ Other  
 (If other, please explain) \_\_\_\_\_  
 NAICS Code \_\_\_\_\_ (Required) Nature of Business \_\_\_\_\_  
 ERISA Plan Number (If Applicable) \_\_\_\_\_

Does your business have more than one location? \_\_\_ Yes (List all locations to be covered under this plan)  
 \_\_\_ No

Location Address	City	State	Zip	Number of Employees
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

(If necessary, attach separate location listings)

Does this Company have common ownership in another company?

\_\_\_ Yes (If yes, please explain) \_\_\_\_\_  
 \_\_\_ No

### ELIGIBILITY

- Number of current employees: Full-time \_\_\_\_\_ Part-time/Seasonal \_\_\_\_\_ Total Employees \_\_\_\_\_
- Number of hours worked per week to be eligible \_\_\_\_\_  
 NOTE: Coverage must be offered to any employee working at least 30 hours or more per week.
- Is plan available to management employees only? \_\_\_ Yes \_\_\_ No
- Does your company have a Medical Leave of Absence policy? \_\_\_ Yes (If yes, please provide a copy) \_\_\_ No
- Waiting Period- Future employees become eligible for insurance (Choose One):  
 \_\_\_ 1st day of the month following 30 days \_\_\_ 1st day of the month following 60 days  
 \_\_\_ 90 days following the hire date (maximum allowed) \_\_\_ Other: \_\_\_\_\_

6. What is the average premium amount paid by member including employee/dependents for previous year of coverage? (Enter value in full dollar amounts)

**Employee \$** \_\_\_\_\_

Please Note: Average monthly premium paid by members equals total premium paid by members divided by total member months. Member months is defined as the number of individuals participating in an insurance plan each month.

The Consolidated Appropriations Act (CAA) requires us to report your group's prescription drug and health care spending data to the Centers for Medicare and Medicaid (CMS). We submit this data, called the RxDC report, on your behalf annually. Failure to provide the requested information will impact your compliance with this mandate.

## PLAN INFORMATION

1. **Renewal Effective Date** \_\_\_\_\_
2. **Deductible** \_\_\_ Calendar-Year Deductible \_\_\_ Plan-Year Deductible
3. **Open Enrollment:** \_\_\_ Yes \_\_\_ No  
(If yes, please check one) \_\_\_ On Renewal Date \_\_\_ Calendar Year
4. Does Avera Health Plans provide COBRA/Continuation of Coverage Services Administration?  
\_\_\_ Yes \_\_\_ No

If no, do you want Avera Health Plans to provide this service? \_\_\_ Yes \_\_\_ No  
(If yes, additional paperwork is needed)

NOTE: This service is provided at no cost.

If no, please provide name of COBRA/Continuation of Coverage Administrator.

Name \_\_\_\_\_ Phone \_\_\_\_\_

Email Address \_\_\_\_\_

5. **Does DAKOTACARE Administrative Services (DAS) currently administer your Premium Only Plans Accounts?** \_\_\_ Yes \_\_\_ No

If no, do you want DAS to administer your Premium Only Plan? \_\_\_ Yes \_\_\_ No

(If yes, additional paperwork is required. Please email [DASFlex@AveraHealthPlans.com](mailto:DASFlex@AveraHealthPlans.com) for forms and fees.)

6. **Flex** \_\_\_ Yes \_\_\_ No (If yes, additional paperwork is required.)
7. **Health Savings Account (HSA)** \_\_\_ Yes \_\_\_ No  
(If yes, additional paperwork is required. Please email [DASFlex@AveraHealthPlans.com](mailto:DASFlex@AveraHealthPlans.com) for forms and fees.)
8. **Fitness Benefit** \_\_\_ ActiveLife and 30% GreatLIFE discount \_\_\_ Free GreatLIFE membership
9. **Life/AD&D Options**

\_\_\_ \$15,000: \$3.30 PEPM

\_\_\_ \$25,000: \$5.50 PEPM

\_\_\_ \$30,000: \$6.60 PEPM

\_\_\_ \$50,000: \$11.00 PEPM

\_\_\_ Decline Life/AD&D Coverage

## AGENT STATEMENT

I certify that to the best of my knowledge, all of the information contained in the Employer Participation Agreement and any attached documents are correct.

Agent's Signature \_\_\_\_\_ Date \_\_\_\_\_

Agent's Name (Please print) \_\_\_\_\_

Agent NPN \_\_\_\_\_ Agent FFM ID \_\_\_\_\_

Agency Name \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Agent Broker Disclosure Fees

For brokers, consultants, service providers and their affiliates or subcontractors providing brokerage or consulting services to ERISA governed group health plans who reasonably expect to receive at least \$1,000 in direct and indirect compensation for the services supplied to the plan must disclose any direct, indirect and transaction-based compensation, including non-cash compensation, of \$250 or more for those services, as well as a description of the services resulting in the payment.

Service providers must give disclosure prior to entering into, amending or extending a contract for services prior to the effective date of the contract, renewal or extension.

Service providers need to notify the plan to any change to the compensation information as soon as possible, but not later than 60 days after a change is identified and within 90 days after a written request for the information from the plan.

## EMPLOYER PARTICIPATION AGREEMENT

The employer hereby applies for or renews group health coverage provided by Avera Health Plans and agrees to be bound by all terms and conditions of the Certificate of Coverage issued to the employer. If your group is subject to ERISA, the Certificate of Coverage is not intended to serve as the ERISA plan document of summary plan description which the employer must provide. The employer acknowledges that the Certificate of Coverage is available for inspection by any person covered by the Certificate of Coverage by contacting us. The employer represents that the information provided on this Small Employer Participation Agreement is complete and true to the best of its knowledge and belief. The employer understands that no insurance will become effective without the written approval of Avera Health Plans and that any fraud or intentional misrepresentation may nullify coverage for employees and dependents. Employer understands that the rates quoted were based on census information and data provided by the employer. Rates are valid from effective date, provided the employer enrolls on the date quoted, but not later than the first of the following month. Rates are subject to approval by the state agency responsible for the regulation of insurance products.

It is further understood that no agent has the authority to alter or amend the Certificate of Coverage or to bind Avera Health Plans by making any promise or representation. We will share with the agent of record the quarterly and/or annual claims reports, unpaid premium notices, and renewal rates upon request.

It is further understood and agreed that benefits under the Certificate of Coverage and the cost of providing those benefits may change. No insurance coverage will become effective until the first full premium has been paid. The employer must provide a completed EFT form or pay 100% of the first month premium (binder payment) in full no later than 30 days from the effectuation date or they will be terminated as never effective. Premiums are due and payable on or before the first day of the month of service. Avera Health Plans will allow a 30-day grace period to the employer for receipt of the premiums. Coverage shall be provided under the Certificate of Coverage during the 30-day grace period as long as the outstanding premium is paid within the grace period. We may suspend the processing of the employer's medical and pharmacy claims for services received during the grace period if your premium is not been paid by the due date. Failure to pay the outstanding premium within the 30-day grace period will cause the Certificate of Coverage to be terminated retroactive to the last day of the month for which payment has been received.

Employer is responsible for identifying eligible employees in accordance with employer policy and applicable state and federal regulations. The employer is responsible for auditing its monthly premium invoice. The employer shall notify Avera Health Plans by completing the Termination of Coverage Form whenever any member ceases to be eligible for coverage, as soon as possible, no later than 30 days after the event that rendered the member ineligible for coverage. The member will be termed for coverage at the end of the termination month or the last day of employment as determined by the employer and premiums must be paid in full for that member. The employer will be liable to pay the premium on behalf of any member for whom the required notice of ineligibility has not been given and may be liable to pay for any claims incurred during the time a person was not an eligible member. If the employer has a covered employee (person who works at least 30 hours per work week) on any form of leave of absence that exceeds 12 weeks in length, the employer agrees to notify us of such employee's status as soon as reasonably possible, and in no event later than 30 days after the leave ends. We will not provide coverage for members of the employer who are on leave of absence for more than 12 weeks per year.

The employer must provide Avera Health Plans with the information needed to administer the Certificate of Coverage and to compute the premium due. The employer has the right to examine our records on the services provided at any reasonable time while this Certificate of Coverage is in force. Avera Health Plans also has this right until all rights and obligations under the Certificate of Coverage are finally terminated.

The Employer will be contacted regarding the renewal of the group health plan. All renewal information including any changes to the group health plan and all applicable documents (Renewal Employer Participation Agreement, Rate Sheet and Member Enrollment Applications, Change Forms and Termination of Coverage Forms) must be fully completed by the Employer and submitted to Avera Health Plans by the close of business on the fifteenth (15th) of the month prior to the effective date. Approval of coverage for eligible employees or dependents is subject to the completeness and accuracy of the aforementioned documents.

*Changes and/or plan approval must be submitted by the 15th of the month prior to the renewal month or the plan will be automatically renewed. For benefit plans that are discontinued, the member will be enrolled in the most comparable benefit plan as determined by Avera Health Plans. For plans that are auto-renewed, changes will not be allowed until the next plan year renewal.*

The plan may terminate or not renew the Certificate of Coverage if one of the following circumstances occurs:

- a) the employer has failed to pay any premium or contributions in accordance with the terms of the Certificate of Coverage or has not made timely premium payments;
- b) the employer performs an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact;
- c) Avera Health Plans discontinues its offering of the type of group health insurance offered;
- d) there is no longer any eligible employer participant or member in connection with the Certificate of Coverage who lives or works in the plan's service area; or
- e) the employer group fails to meet the employer contribution or group participation rules as identified in federal and state regulations.

Any person who, with the requisite intent to defraud or knowing that they are facilitating a fraud against Avera Health Plans in submitting an application or claim combining a false or deceptive statement may be guilty of insurance fraud as specified in applicable state law.

Employer agrees to use any of Avera Health Plans' supplied forms for purposes of performing duties under this agreement. This provision does not, however, require that we create and/or supply forms to groups for COBRA/Continuation of Coverage administration.

Employer acknowledges an understanding of the Renewal Process and that omission of information on the Renewal documents and failure to timely renew may result in auto-renewal or termination of group health plan coverage.

Upon Avera Health Plans' signature, Avera Health Plans agrees to provide coverage to employer as defined in this agreement.

Avera Health Plans and Employer agree to abide by federal and state laws regarding compliance. Responsibilities for disclosure notices are identified in the addendum to this Participation Agreement and may be modified by Avera Health Plans as new regulations require updates.

_____	_____
Authorized Employer Signature	Avera Health Plans Signature
_____	_____
Print Name	Print Name
_____	_____
Title	Title
_____	_____
Date	Date