Avera Health Plans

For Internal Use Only
Effective Date _____
Group Number _____

New Large 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

Are any associated business organizations to be covered? (Parent subsidiary, brother-sister relationships, affiliated groups)

Common Ownership %: _____

___ Yes (If yes, complete below) ___ No

Name	Address	Nature of Business	Business Relationship	Number of Employees
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

(If necessary, attach separate location listing.)

ELIGIBILITY

1. In the past 12 months, have any employees not worked full-time due to injury, illness or disability? ☐ Yes ☐ No
2. Are retirees eligible for coverage? ☐ Yes (If yes, please provide a copy of your retiree policy.) ☐ No
3. Number of current employees: Full-time _____ Part-time/Seasonal _____ Total Employees _____
4. Number of employees who have worked at least 50% of the working days in the preceding calendar year: _____
5. Total number of current eligible employees taking medical coverage:
   a. Number applying for employee coverage only: _____
   b. Number applying for dependent coverage: _____
   c. Number of applicants on COBRA/State Continuation: _____
   NOTE: Documentation of all COBRA/State Continuation participants required for new groups.

   Applicant name(s): _____
6. 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.
7. Is plan available to management employees only? ☐ Yes ☐ No
8. Does your company have a Medical Leave of Absence policy? ☐ Yes (If yes, please provide a copy) ☐ No
9. Does your company have a layoff policy? ☐ Yes (If yes, please provide a copy) ☐ No
10. 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: _____
11. 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.
12. Does your company use electronic data interchange (EDI) for eligibility files or send claim data file to third party administrator (TPA)? ☐ Yes (If yes, complete below) ☐ No

(Name of EDI vendor or TPA)	(Contact Name)	(Email Address)	(Phone Number)
_____	_____	_____	_____

PLAN INFORMATION

1. **Requested Effective Date** _____ The employer acknowledges that the requested effective date is the group's plan year unless the employer designates plan year in a written plan document. The employer agrees to provide Avera Health Plans with a copy of any such written plan document that is in existence. Coverage is not effective until notified in writing.
2. **Deductible** ☐ Calendar-Year Deductible ☐ Plan-Year Deductible
3. **Open Enrollment:** ☐ Yes ☐ No
   (If yes, please check one) ☐ On Renewal Date ☐ Calendar Year
4. **Replace Coverage:** Will this new insurance plan replace other group coverage? ☐ Yes ☐ No
   (If yes, please complete a, b and c below)

a. Prior Coverage Effective Date _____ Prior Coverage Termination Date _____
b. Previous Insurance Carrier _____ Phone (___) _____
c. COBRA/Continuation of Coverage Administrator _____ Phone (___)_____

5. **Worker's Compensation Carrier:** _____ Phone (___) _____

6. Plan Selection(s): _____

_____

_____

_____

7. 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 _____
8. **Does DAKOTACARE Administrative Services (DAS) currently administer your Premium Only Plans Accounts?** ☐ Yes ☐ No **$130 POP document fee (charged every five years)**
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 for forms and fees.)
9. **Flex** ☐ Yes ☐ No (If yes, additional paperwork is required.)
10. **Health Savings Account (HSA)** ☐ Yes ☐ No
(If yes, additional paperwork is required. Please email DASFlex@AveraHealthPlans.com for forms and fees.)
11. **Fitness Benefit** ☐ ActiveLife and 30% GreatLIFE discount ☐ Free GreatLIFE membership
12. **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