Avera Health Plans

For Internal Use Only
Effective Date ____________________
Group Number ____________________

New Employer Participation Agreement

Group Type: ☐ Large Employer Non-Grandfathered ☐ Large Employer Grandfathered
☐ Small Employer Transitional ☐ Small Employer Grandfathered

EMPLOYER INFORMATION

Legal Name of Employer ____________________ President/CEO ____________________
Employer Contact Name ____________________ Phone (______) ____________________ Ext ________
Email ____________________ Fax (________) ____________________
Street Address ____________________ City ____________________
County ____________________ State ____________ ZIP ____________
Mailing Address ____________________ City ____________ State ____ ZIP ________
(If different than Street Address)
Tax Identification Number (TIN) ____________________ NAICS Code (required) ____________________
Nature of Business ____________________

Legal Status: ☐ Proprietorship ☐ Partnership ☐ Corporation ☐ Government Entity ☐ LLC Other, Explain ________

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
Location Address ____________	City ____________	State ______	ZIP ____________	________
Location Address ____________	City ____________	State ______	ZIP ____________	________

(If necessary, attach separate location listing.)

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

☐ Yes ☐ No, If yes complete the following:

Name	Address	Nature of Business	Business Relationship	Number of Employees

(If necessary, attach separate 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 ☐ No If yes, please attach copy of your retiree policy
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. Of the total number of current eligible employees applying for medical coverage:
   a. Number applying for employee coverage only: ________
   b. Number applying for dependent coverage: ________
   c. Number of applicants on COBRA/State Continuation: ______ Applicants name(s): ____________________
      NOTE: Documentation for all COBRA/ State Continuation participants required for new large employer non-grandfathered groups.
   d. Number of hours worked per week to be eligible: ________
      Note: Maximum number of hours cannot exceed 30 hours per week.
   e. Is plan management only? ☐ Yes ☐ No
6. Does your company have a Medical Leave of Absence (LOA) policy? ☐ Yes ☐ No If yes, please attach a copy.
   NOTE: LOA greater than 12 weeks may affect rates.

7. Does your company have a layoff policy? ☐ Yes ☐ No If yes, please attach a copy.
8. 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
   ☐ Other: ______________________________

PLAN INFORMATION

Requested Effective Date: ______________________ The employer acknowledges that the Requested Effective Date is the group's Plan Year, unless the employer designates a different 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.

Defined Contribution Plan: ☐ Yes ☐ No

Premium Only Plans Accounts: Please check services you would like to administer with Avera Health Plans;

Premium Only Plans (If yes, additional paperwork required) $100.00 annually

☐ Yes ☐ No

Selection of the following will require additional paperwork:

FLEX: ☐ Yes ☐ No

$4.85 PPPM plus $250 initial set-up fee and $150 annual renewal fee*

Health Savings Account (HSA): ☐ Yes ☐ No

$3.25 PPPM plus $250 initial set-up fee and $150 annual renewal fee*

*If group opts for both Flex and HSA Administration, only one initial set-up fee and one annual renewal fee is owed.

COBRA/State Continuation of Coverage Administration Services: ☐ Yes ☐ No

If no, please provider name of Coverage Administrator ______________________ Phone ________________

Note: No additional cost to the employer for Avera Health Plans Cobra Services.

1. Deductible: ☐ Calendar Year Deductible ☐ Contract Year Deductible ☐ Explain: ____________________
2. Open Enrollment Offered? ☐ Yes ☐ No
   If yes, check one: ☐ On Renewal Date or ☐ Calendar Year
   (The 30-day Open Enrollment Period begins 45 days prior to and then ends 15 days prior to the Open Enrollment Effective Date unless otherwise agreed upon with Avera Health Plans.)
3. Employer contribution to the premium as of the requested effective date: Employee: ______% Dependent: _____%
4. Employer contribution to the premium on March 23, 2010: Employee: ___________% Dependent: __________%
5. Will this plan replace other group coverage? ☐ Yes ☐ No
   If yes, complete the following and attach a copy of the most recent billing.
   Prior Coverage Effective Date: ______________ Prior Coverage Termination Date: __________________
6. Previous Insurance Carrier ____________________________ Phone ____________________________
7. Worker's Compensation Carrier _________________________ Phone ____________________________

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 ______________________________ Agent TIN ________________ Date____________

Agent Name (please print) ______________________________ Phone ______________________________

Agency Name ______________________________________ Email ______________________________

Address __________________________________ City ____________________ State _____ ZIP _________

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 or 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 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. Should the enrolled group's data provided by the employer vary by more than 10%, we reserve the right to adjust the rates to reflect the enrolled group's actual

data. Rates are valid on effective date, provided the group 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.

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 group's medical and pharmacy claims for services received during the grace period if your premium has 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 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 will be required to pay for any charges 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 unless the extended leave of absence policy is provided with this Agreement. If the employer wishes to have employees remain on leave of absence and still be covered by Avera Health Plans, the employer's premium must be underwritten accordingly to conform with the employer's request.

The employer must provide Avera Health Plans with the information needed to administer the Certificate of Coverage and to compute the premium due. Failure of the employer to provide this information will not void or discontinue a member's coverage. 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 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) the employer has failed to comply with a material Certificate of Coverage provision relating to employer contribution or participation rules;
(d) Avera Health Plans discontinues its offering of the type of group health insurance offered; or
(e) there is no longer any eligible group participant or member in connection with the Certificate of Coverage who lives or works in the plan's service area.

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 group for COBRA/Continuation of Coverage administration.

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

Authorized Employer Signature ______________________ Title ______________________

Print Name ______________________ Date ______________________

Avera Health Plans ______________________ Date ______________________
Chief Executive Officer

Print Name Debra K. Muller

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