Avera Health Plans

For Internal Use Only
Effective Date _____
Group Number _____

RENEWAL
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 _____

Does your business have more than one location? ☐ Yes, list all locations to be covered under this plan ☐ No

								Number of Employees
Location Address		City		State		ZIP		
Location Address		City		State		ZIP		

(If necessary, attach separate location listing.)

ELIGIBILITY

1. Number of current employees: Full-time: _____ Part-time/Seasonal: _____Total Employees: _____
2. Number of hours worked per week to be eligible: _____Note: Maximum hours cannot exceed 30 hours per week.
3. Is plan management only? ☐ Yes ☐ No
4. Waiting Period for new employees to 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: _____

PLAN INFORMATION

1. Renewal Effective Date: _____
2. Open Enrollment Offered? ☐ Yes ☐ No
   If yes, check one: ☐ On Renewal Date or ☐ Calendar Year
3. Deductible: ☐ Calendar Year Deductible ☐ Contract Year Deductible ☐ Other, explain: _____
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 required.
   NOTE: This service is provided at no cost.
   If no, list name of COBRA/State Continuation of Coverage Administrator:
   _____ Phone (____) _____ — _____
5. If applicable, will DAKOTACARE Administrative Services (DAS) continue to administer:

a.	FLEX (FSA):	Yes	No	c.	Health Reimbursement Account (HRA):	Yes	No
b.	Health Savings Account (HSA):	Yes	No	d.	Premium Only Plan (POP):	Yes	No

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