Moda Health Plan, Inc.

1-50 Alaska Group Application

Thank you for choosing Moda Health and Delta Dental of Alaska.

Please forward the completed copy to:
ModaGroupSalesAK@modahealth.com

New Group Enrollment Checklist for Employers and Agents

Please note, if any of the below items are not completed in full, enrollment will be delayed

Is this an existing Moda Health or Delta Dental group with an active line of coverage? ☐ **Yes** ☐ **No**

- ☐ Group Application (completed and signed by the group and agent)
- ☐ Quote sheet for selected plans
- ☐ Enrollment forms/Waiver forms for all eligible employees
  - ☐ Please include hire dates on all enrollment forms/green enrollment spreadsheet
  - ☐ Enrollment forms must match census information
- ☐ Declinations for all employees waiving or opting out (applicable to groups with all levels of participation)
- ☐ First Month's Premium (paid electronically)
- ☐ ESA Agreement
- ☐ EFT (Electronic Funds Transfer) Authorization Form
- ☐ Late Acknowledgement Agreement (if enrolling past the 10th of the month)

For a first of the month effective date, all new group enrollment materials must be received by Moda Health *no later than the 10th of the preceding month*.

Alaska Master Group Application

Groups Sized 1-50

Group name		Employer tax ID#
Effective date	Renewal date	Rate Finder Quote #

Section 1: Group information

The following characters ? | / \ * > < : are not accepted.

Legal name			
Principal business address	City	State	ZIP
Physical business address	City	State	ZIP
Is the group's billing information below the same as their legal name and physical address?		☐ Yes ☐ No	
DBA name (appears on bills)			
Mailing address	City	State	ZIP
Is the group administrator the same as the billing contact?		☐ Yes ☐ No	
Group administrator			
Email address	Phone		
Billing contact			
Email address	Phone		
NAICS code			
What business entity type is the group registered as? (LLC, sole proprietor, s-corp., etc.)			

Section 2: Attestation

ONLY FOR GROUPS WITH ONE EMPLOYEE ENROLLED: Your health plan will not be completed until this form is received. I attest that my group employs at least 1 common-law employee enrolled on the plan in accordance with ERISA and IRS regulations, guidance, and case law. **Note:** Based on applicable federal law, *sole proprietors with no common-law employees and self-employed individuals are not eligible* to purchase (or renew) small-group coverage, Sole proprietors and their spouses are not considered employees for purposes of determining if they are a small employer. However, if they have an employee other than themselves, then the sole proprietorship is eligible for group coverage.	☐ Yes ☐ No
Is this an employee only plan which does not offer coverage to dependents?	☐ Yes ☐ No
Is the group subject to COBRA? Count the employees employed on a typical business day in the previous calendar year. Do not count self-employed individuals, independent contractors, and members of the board of directors. If the group had 20 or more employees during at least 50% of the previous calendar year, the group is subject to COBRA.	☐ Yes ☐ No

Section 2: Attestation - cont.	
Is the group subject to Medicare Secondary Payer (MSP) provision? Count the current total number of full-time employees, part-time employees, seasonal employees and partners. Do not count retirees, COBRA members, individuals on other continuation options or self-employed individuals. If the employee count is 20 or more, the group is subject to MSP.	☐ Yes ☐ No
Will Moda Health cover out of state employees? Employees who reside in the state of Hawaii are not eligible to enroll for medical coverage. **If yes, list state(s) and number of employees in each:** _____ _____ _____	☐ Yes ☐ No
Is the group's principal business address in compliance with the ACA? Principal business address is the address required to be used for rating, per 45 CFR 147.102. It may be different than the address a business uses for billing, etc. For most small groups, principal business address is the address of a substantial worksite that is registered with the State. If the business address isn't registered with the State or doesn't represent a substantial worksite, then one of the following addresses should be used for rating. • The business address within the plan's service area where the greatest number of employees work, live or reside as of the beginning of the plan year. • If there is no such business address, the zip code that reflects where the greatest number of employees within the plan's service area reside as of the beginning of the plan year.	☐ Yes ☐ No
The group consents to the following statements. 1. I have read and understand the information in this group application. For questions about the information on this group application, I have received advice and counsel from my agent or legal counsel. 2. There is no coverage in effect until this Application and premium deposit are accepted by Moda Health and/or Delta Dental of Alaska and an effective date is assigned. If this Application is not accepted, the premium deposit will be refunded. 3. All eligible employees are enrolling in the selected Group Policy and all enrolling employees must meet the eligibility requirements specified above. 4. Minimum premium contribution and participation requirements must be met and maintained for the group to remain eligible for coverage. 5. Employees opting out due to other group or individual coverage are not counted toward the participation requirement. 6. The group's designated representative has reviewed the creditable coverage status of prescription drug plans for Alaska small employer plans at https://modahealth.com/employers/compliance.shtml with the producer before selection of medical plans. 7. The group is responsible for providing the Initial Notice of HIPAA Special Enrollment Rights and Exclusion Periods to all employees on or before the date they enroll in the Group Policy. 8. The group is responsible for providing the Summary of Benefits and Coverage (SBC) to eligible employees at open enrollment and to new hires and newly eligible employees as required under the ACA. 9. The agent listed in this Application is the group's Agent of Record to represent the group in matters of group insurance benefits provided by Moda Health/Delta Dental of Alaska. This appointment is in effect on the same day as the Application and will remain in force until rescinded in writing. 10. The final rates will be based on actual enrollment and may be different than the rates originally quoted, and that additional information may be required to verify eligibility of the group. 11. To the best of the group's knowledge and belief, the statements in this attestation section and all the information provided in this Application is correct. 12. The group understands it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. Moda Health reserves the right to require documentation of employee status and any other criteria related to group and member plan eligibility.	☐ Yes ☐ No

Group Size Determination Form

This form must be completed for all new and renewing groups to determine whether a group is a large employer.

Section 3: Employee Count		
Are you a Controlled Group? If you are a controlled or affiliated group of employers as described under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986, Moda Health must treat all employees within the affiliated group as a single group for purposes of determining group size. You must fill out one group profile form for the entire controlled group. If a controlled group is determined as a large employer, each affiliated employer is part of the large employer even if separately the employer would not meet the definition of large employer. Therefore, each affiliated employer is considered a large group for the purposes of group size determination.	☐ Yes ☐ No	
Employee Counting Instructions A. Total the number of employees working 130 hours for each month of the preceding calendar year. B. Total the number of hours worked by employees working less than 130 hours for each month of the preceding calendar year, but do not include more than 120 hours per employee in a month and divide by 120. This is your Full Time Equivalent (FTE) count of the preceding calendar year. C. Add the numbers from a and b together and divide by 12. This is your group size. When counting employees to determine group size, do not count a sole proprietor, a partner in a partnership, a 2 percent S corporation shareholder, or the spouse of a person who is a sole proprietor, leased or contracted employee, a retired employee, or former employee on continuation coverage.		
1. **On average, how many full time employees did the employer have during the preceding calendar year?** Total the number of employees working 130 hours or more for each month of the preceding calendar year and divide by 12.		
2. **On average how many Full Time Equivalent (FTE) employees did the employer have during the preceding calendar year.** Total the number of hours worked by employees working less than 130 hours for each month of the preceding calendar year, but do not include more than 120 hours per employee in a month and divide by 120. Then divide the total number by 12.		
3. **Total employee count (for determining group size) (#1+#2)** If less than 1, no Alaska small group exists. If more than 50, the group is a large group and not eligible as an Alaska small group. If 1 to 50, the group is a small group.		
	Medical	**Dental**
4. **Out of the number of employees indicated in question #3, indicate the number of employees waiving due to other group or individual coverage**		
5. **Total employee count (for participation requirement) (#3 - #4):**		
6. **Out of the number of employees indicated in question #5, indicate the number of employees opting out of coverage:**		
7. **Total number of employees enrolling (#5 - #6)**		
Comments:		

Section 3a: Employee Participation		
What percentage of employees participate in the plan(s)? (#7 divided by #5) For Voluntary Dental Plans: a minimum of 25% of eligible employees must participate with a minimum of 10 enrolling.		

Section 3b: Signature

To the best of my knowledge, I certify that all the information contained herein is correct. I understand that the final rates will be based on actual enrollment and may be different than the rates originally quoted and that additional information may be required to verify eligibility of the group.

I am the: ☐ **Business Owner** ☐ **Group Administrator** ☐ **Authorized Insurance Agent** ☐ **Other**

Name (printed please)	Signature	Date
X		

Section 4: Eligibility and Employer Contribution

1. **How many hours per week must employees work to be eligible for benefits?** (20 minimum)

2. **What is the eligibility period employees must complete before being eligible for benefits?**

   2a. Time served as a part-time employee will count towards the waiting period when the employee moves to full-time — ☐ **Yes** ☐ **No**

   2b. Is the group subject to ERISA (Employee Retirement Income Security Act of 1974)? — ☐ **Yes** ☐ **No**
   Note: In general, ERISA does not cover group health plans established or maintained by governmental entities, churches for their employees, or plans which are maintained solely to comply with applicable workers compensation, unemployment, or disability laws.

   2c. For initial enrollment only, do you want to waive the waiting period for all current eligible employees? — ☐ **Yes** ☐ **No**

3. **Is Domestic Partner coverage available?** ☐ **Yes - either gender/sex** ☐ **No**

4. **What percentage of your medical premium is contributed by the employer?**
   If choosing multiple plans, the minimum contribution is 50% of the plan with the lowest premium.

Your contribution for employee (minimum is 50%)	Your contribution for dependents

5. **What percentage of your dental premium is contributed by the employer?**

If Contributory Plan: Your contribution for employee (minimum is 50%) If Voluntary Plan: Your contribution for employee (minimum is 0%)	Your contribution for dependents

Section 5: Employee participation

1. **Medical Participation:**

   - For groups of 1-4, minimum of 100% of eligible employees must participate.
   - For groups of 5-50, minimum of 70% of eligible employees must participate.

2. **Contributory Dental Participation:**

   - Delta Dental
   - For dental only groups of 2-4, minimum of 100% of eligible employees and eligible dependents must participate.
   - For groups of 5-50, minimum of 70% of eligible employees and 25% of eligible dependents must participate.

3. **Voluntary Delta Dental Participation:**

   - For groups of 2-50, minimum of 2 enrolling employees or 25% eligible employees, whichever is greater.

1-4 enrolled employees	5-50 enrolled employees

Section 6: Types of coverage

1. **Rate Finder Medical Plan design 1 name:**		
2. **Rate Finder Medical Plan design 2 name:**		
3. **Rate Finder Medical Plan design 3 name:**		
For groups selecting multiple medical plans only: Please note, a maximum of three plans may be selected from our plan portfolio with a minimum of one enrolled in each plan.		
4. **Rate Finder Dental Plan design name:**		
5. **Rate Finder Orthodontia Plan design name:** Only those groups with 15 or more enrolling are eligible for Orthodontia Plans.		
6. **Rate Finder DeltaVision® Plan design name:**		
9. **If selecting a Moda Health medical and a Delta Dental dental plan, indicate if enrollment will be standalone or integrated.**	☐ **Standalone** *(can enroll in either plan)*	☐ **Integrated** *(must enroll in both)*
10. **Do you currently have another medical group policy?** If yes, please indicate the carrier:		☐ **Yes** ☐ **No**
11. **Do you currently have another dental group policy?** If yes, please indicate the carrier:		☐ **Yes** ☐ **No**
12. **If this plan is replacing an existing plan, will members receive deductible credit from a previous plan?**		☐ **Yes** ☐ **No**
13. **If this plan is replacing an existing plan, will members receive out-of-pocket credit from the previous plan?**		☐ **Yes** ☐ **No**

Section 7: COBRA Administration and Premium Only plan	
1. Do you have a Premium Only Plan? Premium Only Plan (POP), specifically under Section 125, is necessary and allows employees to pay their portion of health insurance premiums with pre-tax dollars, leading to tax savings for both employees and employers. 1a. If no, will you elect a Premium Only Plan through Benefit Help Solutions (BHS)?	☐ Yes ☐ No ☐ Yes ☐ No
2. Do you use a COBRA Third Party Administrator (TPA)? If your group is 20 or greater and is choosing BenefitHelp Solutions as your TPA for standalone COBRA, please call 1-800-556-3137 to speak with a Representative regarding a quote. 2a. If yes, enter the TPA Name and contact information: Name Address Phone 2b. If no, will you elect COBRA administration through BenefitHelp Solutions (BHS)?	☐ Yes ☐ No ☐ Yes ☐ No
3. Who will be remitting payment to Moda Health/Delta Dental for COBRA premiums?	☐ Group ☐ TPA

Section 8: Premium Payment Information
Group name

All monthly premium payments are to be submitted by the group using the eBill process within the Employer Dashboard.

Once your application has been processed and we have your group set up in our system, you will receive access to the Employer Dashboard. Once you activate your account you can manage the monthly bill within our eBill tool, including paying your first month's premium payment (Binder Payment) and setting up how future payments are made. You will also be able to view your group's monthly invoices through eBill.

Access to eBill will be fully functional on your group's effective date.

For more information about the eBill tool, Employer Dashboard, or information on alternative ways of making your first premium payment, please contact your sales team contact or email modagroupsales@modahealth.com.

Section 9: Agent information	
Agent name	Agency name
Agent NPN	Agency tax ID

By signing below, I agree that the signature will be the electronic representation of my signature and initials for all purposes when I (or my agent) use them on documents, including legally binding contracts.

Authorized signature for group X	Title
Authorized signer's printed name	Date
Authorized agent signature X	Date
Authorized agent's printed name	
Moda Health/Delta Dental representative signature X	Date

Electronic Services Agreement

This Electronic Services Agreement ("Agreement") states the terms and conditions that govern the use of online services by_____("Employer") through Employer's online account (the "Account").

1. **Employer Dashboard**

Employer Dashboard includes the following (individually and collectively, the "Services"):

A. Online Services. Online Services include any or all of the following services dependent upon eligibility criteria: review of employee and dependent enrollment and claims data, electronic entry, modification, termination, designation of primary care physicians, ID card requests, and other group enrollment related functions that may become available from time to time.

Employers using electronic eligibility file processing to manage enrollment and eligibility will be able to access information on the dashboard, but will not be able to add, change or terminate eligibility through the Employer Dashboard. Other functions such as ID card requests, designation of primary care providers and other functions may be available from time to time.

B. eBill. eBill includes the electronic distribution of billing invoices and payment of premiums.

i. Participation. By signing this Agreement, Employer consents to the electronic distribution of billing invoices.

ii. Payment. Payment must be posted by the due date noted on the billing invoice. Please allow up to three days for processing of online payments. Immediate and past-due payments will not be accepted through eBill; Employer should contact their Membership Accounting specialist or Sales and Service representative for immediate or past-due payments.

Employer has the ability to schedule payments for specific dates. Scheduled payments can be changed or cancelled at any time prior to being processed. Moda Health and Delta Dental will not accept scheduled payments on eBill as proof of payment until that payment has been marked "PAID" on the payment history screen.

iii. Account Information. eBill uses email as the primary source of communication. Employer will be notified when statements are available online or if a payment cannot be processed. Employer may view or print invoices through the Account. Employer may change the group's bill delivery preference or discontinue email notifications at any time by changing their preferences. Employer also has the ability to select to be notified when there is payment confirmation. Employer shall ensure that Employer email information is updated.

C. Other online features, included but not limited to; reporting when applicable, ability to generate or view enrollment census, etc.

D. Online access is based on the role assignments below:

Company Admin: This is the highest level of access available to an employer. Specifically, a Company Admin is able to access all features available online (enrollment, billing and claims data and/or reporting when applicable). Each group will have at least one Company Admin. The Company Admin has the ability to assign roles as outlined below within their organization and manage access to those roles as follows;

Group Admin: Allows access to view employee and dependent eligibility, make changes to enrollment including address changes, termination of coverage, and primary care provider assignments. The above services are not currently available to employers utilizing an electronic eligibility file. The Company Admin can determine if access to claims data or reporting data (when available) is permitted for this role.

Financial Admin: Allows access to view bills, make payments and receive notification of bills electronically. Able to view enrollment data, however there is no access to process enrollment changes or request ID cards. A Company Admin can determine if access to claims data or reporting data (when available) is permitted for this role.

Company Admin will remove any access for any employee who was granted access no later than the last day of employment with the employer.

2. Company Admin Contact Information

The Contact Person is the person within the Employer organization who is designated by the Employer to authorize user access to the Account. If Employer changes the Company Admin Contact Person, Employer shall notify Moda Health and/or Delta Dental in writing no later than five business days after such change.

Company admin contact person		
Phone number	Ext	Company admin email address

3. Agreement

Use or access of approved Services by Employer or Employer's authorized representatives constitutes agreement to the terms and conditions of this Agreement. Moda Health Plan, Inc. ("Moda Health") and Delta Dental of Alaska ("Delta Dental") may amend or change this Agreement from time to time, in its sole discretion, by providing Employer written notice by electronic or regular mail, or by posting the updated terms on Moda Health and Delta Dental's website. Continued use of the Services following such change or amendment will be considered Employer's agreement to the change or amendment.

Employer may discontinue use of the Services at any time if these terms and conditions are unacceptable.

4. Confidentiality

Employer shall maintain the security and confidentiality of the information maintained through the Account, including individually identifiable health information of a member as defined in 45 CFR §160.103 (collectively the "Information"), as required by all applicable state and federal laws. Employer agrees not to use or further disclose the Information for any purpose except as necessary to carry out this Agreement and to administer Employer's health plan. Employer will use appropriate physical, technical and administrative safeguards to prevent use or disclosure of the Information other than as provided for by this Agreement. Employer will maintain confidentiality of user identifications and passwords and prevent any unauthorized individual(s) from accessing the Account and/or using Information in a manner contrary to this Agreement.

5. Access, Passwords, and Security

Employer agrees to follow the security and privacy protocols established by Moda Health and Delta Dental and described in the user guide, website terms of use, or other related documentation that may be provided by Moda Health and Delta Dental (collectively, the "Security and Privacy Protocols"), to ensure that all transactions are authorized and to protect all Information from improper access.

6. Reporting Violations

Employer agrees to immediately notify Moda Health and Delta Dental if Employer becomes aware of any of the following:

a. Any loss or theft of access codes or passwords

b. Any unauthorized use of any access codes or passwords

c. Any unauthorized use of the Account

d. Any loss, theft or unauthorized use of Information

e. Any loss or theft of hardware which contains Information

Employer further agrees to make any and all reasonable efforts to correct or mitigate the effects of any such occurrences and to prevent reoccurrence.

7. Enrollment Materials

Employer agrees to retain all written and electronic enrollment materials, including but not limited to, enrollment forms, applications, personal data sheets, and any forms required to update or change employee information (collectively, "Enrollment Materials"), for a period of 10 years from the date they are received by Employer. Employer shall provide Moda Health and Delta Dental with reasonable access to such Enrollment Materials upon request.

8. Indemnification

Employer agrees to indemnify and defend Moda Health and Delta Dental from and against any and all claims, losses, damages, liability, costs and expenses (including but not limited to defense costs and reasonable attorneys' fees) arising from or related to Employer's violation of this Agreement, misuse of the Information, or violation of any third-party's rights, including violation of any proprietary right and invasion of any privacy rights. This obligation will survive the termination of this Agreement.

9. Termination

Moda Health and Delta Dental reserve the right to terminate Employer access to the Account, or any portion of the Services in its sole discretion, at any time, without notice and without limitation, for any reason whatsoever, including but not limited to unauthorized use of Employer access codes or passwords, misuse or unauthorized use of the Information, failure to adhere to policies set forth in the Security and Privacy Protocols, or breach of this Agreement.

10. Assignment

Employer may not assign its rights, interests or obligations or any part thereof under the Agreement without prior written permission of Moda Health and Delta Dental.

11. Severability

If any provision of this Agreement shall be invalid or unenforceable in any respect for any reason, the validity and enforceability of any such provision in any other respect and of the remaining provisions of this Agreement shall not be in any way impaired.

12. Terms of Use

Employer shall abide by any additional Terms of Use posted on the Moda Health and Delta Dental website.

Employer represents and warrants that the person signing this Agreement has the authority to do so, and is entering into this Agreement on behalf of Employer and all existing and future employees.

The individual signing this Agreement on behalf the Employer must be the owner of the business in a sole proprietorship; a partner in a partnership; the designated principal in a limited partnership, corporation or other licensed entity; an officer; or supervisor or manager at the Employer entity.

By signing this Agreement, Employer acknowledges that Employer has read, understands and accepts the terms and conditions as stated in this Agreement.

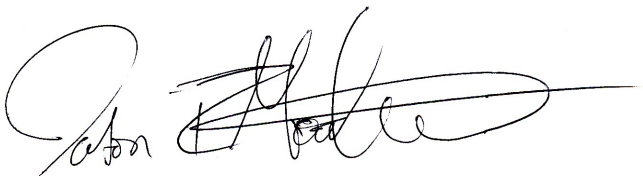
Employer	
Signature X	Title
Date	Tax identification #

Moda Health and Delta Dental of Alaska normally requires new group applications be submitted and received by the 10th of the month prior to the effective date. At your direction, we have accepted the application for this group after the 10th.

Because we are accepting this information after the 10th, we are asking you to acknowledge that all aspects of your group's set-up may not be completed by the 1st. Your group's information may not be completely set up in the system, the member's identification cards may not be ready and in the member's hands prior to the effective date.

Moda Health and Delta Dental is committed to completing this process in a timely fashion and will commit to providing your group set-up as timely as possible. Again, thank you for your business!

Best Regards,



Jason Gootee

VP, Sales & Strategic Market Development

X

Group Administrator/Authorized Representative

Producer/Agent