Moda Health Plan, Inc.

# Moda Health 2-50
# Idaho Group Plan Confirmation Form

Please complete the below application and submit to Moda Health 20 days prior to the effective date of your policy to avoid disruption of coverage. If you have any questions, please contact your Service Rep or Account Manager.

| Legal name | |
|---|---|
| Group Number | Effective Date of Renewal |

What plan options would you like to be renewed with?

| |
|---|
| Medical Plan Option 1 |
| Medical Plan Option 2 |
| Medical Plan Option 3 |
| Vision Plan |

A maximum of 3 plans may be selected from our plan portfolio with a minimum of 1 member enrolled in each. For Part D creditable plans, please review the creditable coverage status of prescription drug plans for Idaho small employer plans at www.modahealth.com/employers/compliance.shtml.

| | |
|---|---|
| **Is the group a small employer based on the Group Size Determination Form?** | ☐ Yes ☐ No |
| **Is the group subject to COBRA?**<br>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 |
| **Is the group subject to Medicare Secondary Payer (MSP) provision?**<br>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 |

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| **Would you like to update your probationary period?**<br>If yes, what probationary period do you select?<br>☐ Date of hire<br>☐ 30 days<br>☐ 30 days, plus one month orientation period<br>☐ 60 days<br>☐ 60 days, plus one month orientation period<br>1st of the month following:<br>☐ Date of hire<br>☐ Date of hire or date of hire when 1st of the month<br>☐ 30 days<br>☐ 30 days, plus one month orientation period<br>☐ 60 days<br>☐ 60 days,plus one month orientation period | ☐ Yes ☐ No |
| **Are you making any changes to your contribution, eligibility, or plan?**<br>If so, please outline the changes below: | ☐ Yes ☐ No |
| **Are your group contacts changing?** | ☐ Yes ☐ No |

| Group administrator | | |
|---|---|---|
| Name | Phone | Email |
| | | |

| Billing contact | | |
|---|---|---|
| Name | Phone | Email |
| | | |

**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.**

**For questions about the information on this form, I have received advice and counsel from my agent or legal counsel.**

| | |
|---|---|
| Authorized Signature for Group<br>X | Date |
| Authorized Signer's Printed Name | Title |

# Group Size Determination Form

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

| Group Name | |
|---|---|
| | |
| **Are you a Controlled Group?**<br>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.<br>**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.<br>**C.** Add A + B, then divide the total by 12. This is your group size.<br>*Note: 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, a temporary, seasonal, leased or contracted employee, a retired employee, or former employee on continuation coverage.* |

| | |
|---|---|
| **1. Employee Count (Determines Group Size)**<br>Please enter the average number of common-law employees who were employed during the previous calendar year (January–December).<br>If less than 1, no Idaho small group exists. If more than 50, the group is a large group and not eligible as an Idaho small group. If 1 to 50, the group is a small group.<br>This count should include full-time, seasonal, and union employees that work inside or outside the State of Idaho, or any employees affiliated company. Include business owners, corporate officers, and partners only if they are common-law employees. Contracted 1099 individuals should not be included. "Common-law employees" are defined under the Employee Retirement Income Security Act of 1974 (ERISA) and Internal Revenue Service (IRS) as an individual who qualifies as an employee based on traditional employer-employee relationship principles, primarily determined by the level of control the employer has over the worker. Consult with your legal counsel to ensure that your employees are considered common-law employees under the law. | |
| | **Employee counts** |
| **2. Out of the number of employees mentioned above, indicate the number of employees waiving due to other group or individual coverage** | |
| **3. Total employee count (for participation requirement) (#1 - #2):** | |
| **4. Out of the number of employees indicated in question #3, indicate the number of employees opting out of coverage:** | |
| **5. Total number of employees enrolling (#3 - #4)** | |

## Employee Participation

**What percentage of employees participate in the plan(s)? (#5 divided by #3)**

Medical Participation:

- For groups of 2-4, minimum of 100% of eligible employees must participate.
- For groups of 5-50, minimum of 70% of eligible employees must participate.

Vision:

**Employer paid plans:**

- Groups must choose a medical plan in order to choose a vision plan.
- Dependents under age 19 are not eligible for vision coverage outside the pediatric vision coverage embedded in the medical plans

**Voluntary paid plans:**

- At least one employee must elect coverage.
- Groups must have a medical plan to offer voluntary vision.
- Member can choose medical only or medical with vision. Subscriber makes the election for the family.

Minimum participation requirement does not apply for group renewals purchased between November 15 and December 15.

## 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 | | |