Moda Health Plan, Inc.

Alaska Large Employer Group Application (51+)

Thank you for choosing Moda Health and Delta Dental.

Please forward the completed copy to:
ModaGroupSales@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)

Does the group have COBRA eligible lines of coverage other than Moda Health (medical coverage)? ☐ Yes ☐ No

☐ Quote sheet for selected plans

☐ Enrollment forms have been reviewed for the following:
- ☐ Enrollment forms/Waiver forms provided for all eligible employees
- ☐ Please include hire dates on all enrollment forms/green enrollment spreadsheet
- ☐ Enrollment forms match census information

☐ First Month's Premium (paid electronically)

☐ Electronic Services Agreement

☐ 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.

Health plans provided by Moda Health Plan, Inc. Dental plans in Oregon provided by Oregon Dental Service, dba Delta Dental Plan of Oregon. Dental plans in Alaska provided by Delta Dental of Alaska.
Delta Dental is a trademark of Delta Dental Plans Association.

Alaska Large Employer Group Application *Group Size 51+*

Effective date: _____

Group information

Legal name:			Tax ID #:
DBA name (appears on bills):			NAICS:
Physical address (no P.O. box):	City:	State:	ZIP:
Group administrator:			
Group administrator phone #:			
Group administrator email address:			
Renewal date:	Notification Month/Year:		
Is the group subject to ERISA (Employee Retirement Income Security Act of 1976)? 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.			☐ Yes ☐ No

Form of organization (check all that apply):

☐ Association Filed date: _____ Approval #: _____

☐ Trust Filed date: _____ Approval #: _____

☐ Bargaining agreement (union)

Effective date: _____

Expiration date: _____

☐ Corporation ☐ LLC ☐ Non-profit ☐ Partnership ☐ S Corporation ☐ Sole proprietor ☐ Government entity

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

For employees (minimum 50%): _____ For dependents: _____

What percentage of the dental premium is to be contributed by the employer?

For employees (minimum 50%): _____ For dependents: _____

Existing coverage

Please provide the name for the current insurance carrier(s), both medical and dental:

Medical: _____ Dental: _____

If this plan is replacing an existing plan, will members receive credit from the previous plan? ☐ Yes ☐ No

If Yes, check the type(s) of report(s) below that will be available for applying credit:

☐ Medical deductible ☐ Dental deductible ☐ Other: _____

Group Size Determination Form

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

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
1. **Employee Count (Determines Group Size)** Please enter the average number of common-law employees who were employed during the previous calendar year (January–December). This count should include full-time, seasonal, and union employees that work inside or outside the State of Alaska, or any employees from any 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, 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: • A minimum of 70% of eligible employees must participate. Non-voluntary Delta Dental Only: • A minimum of 70% of eligible employees must participate. Voluntary Delta Dental: • A minimum of 25% of eligible employees must participate.	

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) X	Signature	Date

Group Structure Worksheet

Subgroup setup			
Our standard subgroup setup designates if subscribers are "Active" or have elected "COBRA". Subgroups can be used to categorize your membership by a different billing location or entity. Custom subgroups will create billing statements, separate your members on your invoice and impact reporting (if applicable) for each subgroup defined. If you require additional explanation or assistance with subgroup setup, please speak with your sales representative.			
Subgroup name	**Subgroup billing contact name (if different than group administrator)**	**Subgroup billing address (if different than physical address)**	
Active	Name:	Address:	
	Phone number:	City:	
	Email:	State:	Zip:
COBRA	Name:	Address:	
	Phone number:	City:	
	Email:	State:	Zip:
	Name:	Address:	
	Phone number:	City:	
	Email:	State:	Zip:
	Name:	Address:	
	Phone number:	City:	
	Email:	State:	Zip:
Is domestic partner coverage available?		☐ Yes, either gender/sex ☐ No	

Class setup

Our standard setup groups all employees into one single class called "All Employees". If a medical group has out of state employees, we will include an Outside the Service Area plan, so that you can distinguish the plan that uses our local PPO Medical network, and those that will use our National network. Class setup allows you to define the benefits available to a subset of membership. If all of your employees must work the same hours, meet the same probationary period and have the same benefits available to them, our standard setup should work.

If you require additional explanation or assistance with class setup, please speak with your sales representative.

Service area for medical groups

Will employees who reside outside of Alaska, Idaho, Oregon and Southwest Washington (Clark and Cowlitz counties) be covered by a Moda Health medical plan? ☐ Yes ☐ No

If yes, list state(s): _____

Note: Employees who reside in the state of Hawaii are not eligible to enroll for medical coverage.

How many hours per week must an employee work to be eligible for benefits? (minimum 20): _____

Will the minimum hours apply to all eligible employees? ☐ Yes ☐ No

If no, please describe: _____

What is the waiting period an employee must complete before becoming eligible for benefits?

☐ Date of hire, no waiting period

☐ Date of hire, plus one month orientation period

OR

1st of the month following:

☐ Date of hire

☐ Date of hire, plus one month orientation period

☐ Date of hire or date of hire when 1st of the month

☐ Date of hire or date of hire when 1st of the month, plus one month orientation period

☐ 30 days

☐ 30 days, plus one month orientation period

☐ 60 days

☐ 60 days, plus one month orientation period

☐ 90 days (dental only)

☐ 90 days, plus one month orientation period (dental only)

☐ Other, please describe _____

Will the eligibility period apply to all eligible employees? ☐ Yes ☐ No

If no, please describe: _____

_____

For employer's initial enrollment only, will the waiting period be waived for all current eligible employees?	☐ Yes ☐ No
If a part-time employee becomes eligible for coverage, does part-time employment count towards the waiting period for full-time employees?	☐ Yes ☐ No

Will all plans be available to all employees? ☐ Yes ☐ No

If no, please describe: _____

_____

Will the Medical and Dental plan be integrated (bundled)? ☐ Yes ☐ No

If yes, indicate which lines are integrated:

☐ **Medical, Dental, Vision** ☐ **Medical, Dental**

COBRA Administration and Premium Only plan

Moda Health's subsidiary, BenefitHelp Solutions (BHS), provides COBRA administration for Moda Health Medical Groups between 51 – 99 employees at no additional cost.

Fees will apply for employers with 100+ eligible employees and/or when BHS provides administration for product lines outside of Moda Health.

If a group has COBRA eligible plans outside of Moda, please contact BHS for COBRA administration fees: BHS-S&Steam@benefithelpsolutions.com

1. **Do you have a Premium Only Plan?** ☐ Yes ☐ No
   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

2. **Does the group use a third-party administrator (TPA) for COBRA or Retiree Administration?** ☐ Yes ☐ No

   2a. If yes, enter the TPA Name and contact information:

TPA Name
Address
Phone

   2b. If no, will you elect COBRA administration through BenefitHelp Solutions (BHS)? ☐ Yes ☐ No

   2c. If yes, should BHS charge an additional 48% administrative fee for COBRA participants that meet the disability requirement and are eligible for an additional 11 months of COBRA? ☐ Yes ☐ No

   List all company contacts who should have Online COBRA employer portal access:

   _____

Phone

   ☐ **Check here Online COBRA broker portal access should be granted.**

   Broker's tax ID number _____

3. **Who will be paying the COBRA premiums?**

   ☐ **Employer** ☐ **TPA – Do not print bill** ☐ **TPA – Print bill**

Health Savings Account (HSA)

Health Savings Account (HSA)

Complete only if a Moda HSA-eligible health plan will be offered.

Moda offers integration with BenefitHelp Solutions, our preferred HSA Administrator and subsidiary company. This integration allows BenefitHelp Solutions to automatically set up health savings accounts for each employee enrolled on a Moda HSA-eligible health plan and offers employees the ability to pay providers directly from their HSA. The integrated HSA administration with BenefitHelp Solutions is **provided at no cos**t to fully insured groups. Employers will utilize the BenefitHelp Solutions employer portal for posting HSA contributions and a signed ACH form will be required to authorize BenefitHelp Solutions to pull HSA contribution amounts from the employer's designated bank account.

1. **Will the group elect BenefitHelp Solutions to administer its health savings accounts?** ☐ Yes ☐ No

   If yes, complete the below information:

   1a. Will you be transferring current Health Savings Account balances? ☐ Yes ☐ No

   1b. Will you be sending a bulk transfer for all employees? ☐ Yes ☐ No

   HSA employer contribution amount: _____

   Frequency: ☐ Annually ☐ Per Pay Period ☐ Per Month

   1c. If divisions are required for reporting or funding list the division names:

   _____

Company Contacts

Only the individuals listed below will be authorized to communicate with the BenefitHelp Solutions Employer Services team.

Primary employer contact (this contact will have access to the BenefitHelp Solutions employer portal)

Name			Title
Email address			**Report notifications:** ☐ Yes ☐ No
Phone number	Ext.	Secondary Phone	Ext.

Secondary employer contact (this contact will have access to the BenefitHelp Solutions employer portal)

Name			Title
Email address			**Report notifications:** ☐ Yes ☐ No
Phone number	Ext.	Secondary Phone	Ext

Consultant/Broker contact

Name			Title
Email address			**Report notifications:** ☐ Yes ☐ No
Phone number	Ext.	Secondary Phone	Ext

Payment Information

Premium Payment Method

Group legal name

☐ ACH pull (complete EFT information) ☐ ACH push (payment will be set up through eBill, please see notes below):

Instructions for eBill payments

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.

Instructions for EFT payments

1. Provide your banking information
2. If you have ACH security in place, please add company ID 3930989307 to your ACH filter list
3. For a checking account, please attach a VOIDED check
4. For a savings account, attach a deposit slip

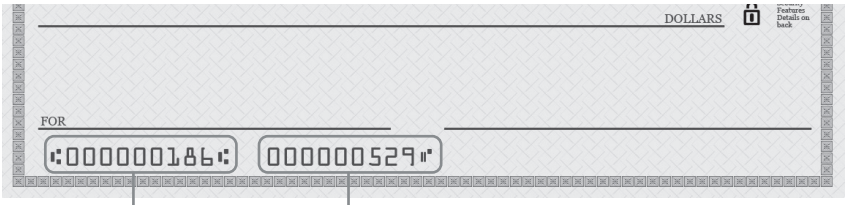
Effective date	Date of transfer ☐ 25th (prior month for future month's premium) ☐ 1st

Transaction type

☐ Binder and reoccuring payments ☐ Reoccuring payments only ☐ Binder payment only

I (we) hereby authorize Moda Health hereinafter called COMPANY, to initiate debit entries to my (our) Checking account indicated below and the depository named below, hereinafter called DEPOSITORY, to debit the same to such account.

Depository name	Branch	
City	State	ZIP
Bank routing no.	Account no.	



9-digit routing no. *Account no.*

Agent / Group Signature Page

Agent information	
Agent name	Agency
NPN:	Tax ID# (For tax purposes, please indicate if tax ID or S/S #): ☐ Tax ID ☐ S/S #

I hereby make application to Moda Health/Delta Dental, on behalf of the Group, for the Group Policies indicated in this group application.

I understand that there is no coverage in effect until Moda Health/Delta Dental accepts this Application and premium deposit and establishes an effective date. If this Application is not accepted, the premium deposit will be refunded.

I hereby certify all eligible employees are enrolling in the selected Group Policies and all enrolling employees meet the eligibility requirements specified above. In addition, I hereby appoint the above agent as our Agent of Record to represent us in matters of group insurance benefits provided by Moda Health/Delta Dental. This appointment is in effect on the same day as this Policy and will remain in force until rescinded in writing.

Applicable for medical policies only: I hereby acknowledge responsibility on behalf of the Group to provide the Summary of Benefits & Coverage (SBC), Uniform Glossary, and the Initial Notice of HIPAA Special Enrollment Rights and Exclusion Periods to all employees on or before the date they enroll in the selected Group Policies.

Authorization	
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) uses them on documents, including legally binding contracts.	
Authorized signature for GROUP X	Authorized signer's title
Authorized signer's printed Name X	Date

Authorized AGENT signature X	
Authorized agent's printed name X	Date
Marketing 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 Plan of Oregon 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.

2. 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.

3. 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.

4. 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.

5. 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.

6. 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.

7. 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.

8. 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.

9. 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.

10. 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 #	

Late Acknowledgement

Welcome

Moda Health and Delta Dental of Oregon and 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

X _____

Producer/Agent