Group Size Determination Form

For group medical plans purchased outside of the SHOP marketplace, this form must be completed for all new and renewing groups to determine whether a group qualifies as a small employer.

Moda Health must treat an employer as a small employer if the employer has at least one but not more than 50 employees on average during the preceding calendar year and has at least one employee on the first day of the plan year.

Controlled and Affiliated Groups:

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 purpose of group size determination.

Employee Counting Instructions:

a) Total the number of employers 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, the spouse of a person who is a sole proprietor, a temporary, seasonal, leased or contracted employee, a retired employee, or a former employee on continuation coverage.

SECTION A

Is this an employee only plan?		
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 Oregon small group exists. If more than 50, the group is a large group and not eligible as an Oregon small group. If 1 to 50, the group is a small group.		0
4. How many employees does the employer expect to have on the date coverage will take effect? The employer must have at least one employee on the date coverage will take effect in order to be issued small group coverage.		
5. How many employees will be eligible for coverage?		
6. Out of the number of eligible employees indicated in question #5, indicate the number of employees *not* eligible for coverage due to *group's eligibility rules*:		
7. Total number of group eligible employees *(#5 - #6)*:		0
	Medical	**Dental**
8. Out of the number of employees indicated in question #7, indicate the number of employees waiving due to other *group or individual* coverage:	0	0
9. Total employee count (for participation requirement) (*#7 - #8):*	0	0

10. Out of the number of employees indicated in question #9, indicate the number of employees opting out of coverage: Count employees choosing not to take coverage here.		
11. Total number of employees enrolling (#9 - #10):	0	0
12. Total number COBRA/State Continuation enrollees (include primary insured's only):		
13. Total number of employees and COBRA or state continuation enrollees *(#11 + #12)*:	0	0
14. To determine if your group is subject to COBRA, indicate how many employees you 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 plan qualifies for COBRA continuation). Otherwise, the group qualifies for state continuation.		
15. What type of employees are you offering coverage to: a. All employees working 17.5 hours or more per week b. All employees working the minimum hours required by your specific company in order to qualify for benefits (i.e. 40 hours per week)		
16. To determine if your group is subject to Medicare Secondary Payer provision, do you have 20 or more employees for each working day in each 20 or more calendar weeks in the current calendar year or the preceding calendar year? Count all employees on the employment payroll. Do not count retirees, COBRA qualified beneficiaries, individuals on other continuation options or self-employed individuals.		
Comments:		

EMPLOYEE PARTICIPATION	**Medical**	**Dental**
17. What percentage of *employees* participate in the plan(s)?*(#11 divided by #9)* For groups of 1-4 employees, a minimum of 100% of eligible employees must participate. For groups of 5-50 employees, a minimum of 70% of eligible employees must participate. **For Voluntary Dental Plans, a minimum of 25% of eligible employees must participate with a minimum of 10 enrolling.**	NaN	NaN

DEPENDENT PARTICIPATION

If you checked "yes" to EMPLOYEE ONLY PLAN on page 1, please mark "N/A" for dependent participation in question #18 below. Please note that under an employee only contract, Moda will not allow any future dependents to be covered on this plan.

If you checked "no" to EMPLOYEE ONLY PLAN on page 1, but currently have no eligible dependents to enroll, please indicate 0% for dependent participation in question #18 below. Please note that under an employee + dependent contract, Moda will allow any future dependents to be covered on this plan.

If you checked "no" to EMPLOYEE ONLY PLAN on page 1, and currently have eligible dependents to enroll, please calculate your current dependent participation and indicate this percentage in question #18 below. Please note that under an employee + dependent contract, Moda will allow any future dependents to be covered on this plan.

	Medical	**Dental**
18. What percentage of *dependents* participate in the plan(s)?		

SECTION B

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:

Name *(printed please):*		**Signature:**		**Date:**	

Moda Health nondiscrimination notice

Moda, Inc. complies with applicable federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability or sex.

Moda provides free, timely aids and services to people with disabilities to help them communicate with us effectively. These accommodations include sign language interpreters and written information in other formats.

If your primary language is not English, Moda also provides free, timely interpretation services and/or materials written in other languages.

If you need any of the services listed above, contact:

Customer Service,
888-217-2363 (TDD/TTY 711)

If you believe that Moda has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a written grievance by mailing or faxing it to:

Moda, Inc.
Attention: Appeal Unit
601 SW Second Ave.
Portland, OR 97204
Fax: 503-412-4003

If you need assistance filing a grievance, please call Customer Service.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone to:

U.S. Department of Health
and Human Services
200 Independence Ave. SW, Room 509F
HHH Building, Washington, DC 20201

800-368-1019, 800-537-7697 (TDD).

Office for Civil Rights complaint forms are available at hhs.gov/ocr/office/file/index.html.

Moda's efforts to assure nondiscrimination are coordinated by:

Tom Bikales, VP Legal Affairs
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

Health plans in Oregon and Alaska 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. 15019019 (8/16)

DELTA DENTAL
Delta Dental of Oregon & Alaska

moda HEALTH

ATENCIÓN: Si habla español, hay disponibles servicios de ayuda con el idioma sin costo alguno para usted. Llame al 1-877-605-3229 (TTY: 711).

注意：如果您說中文，可得到免費語言幫助服務。請致電1-877-605-3229（聾啞人專用：711）

CHÚ Ý: Nếu bạn nói tiếng Việt, có dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Gọi 1-877-605-3229 (TTY:711)

주의: 한국어로 무료 언어 지원 서비스를 이용하시려면 다음 연락처로 연락해주시기 바랍니다. 전화 1-877-605-3229 (TTY: 711)

PAUNAWA: Kung nagsasalita ka ng Tagalog, ang mga serbisyong tulong sa wika, ay walang bayad, at magagamit mo. Tumawag sa numerong 1-877-605-3229 (TTY: 711)

ВНИМАНИЕ! Если Вы говорите по-русски, воспользуйтесь бесплатной языковой поддержкой. Позвоните по тел. 1-877-605-3229 (текстовый телефон: 711).

تنبيه: إذا كنت تتحدث العربية، فهناك خدمات مساعدة لغوية متاحة لك مجانًا. اتصل برقم 1-877-605-3229 (الهاتف النصي: 711)

ATANSYON: Si ou pale Kreyòl Ayisyen, nou ofri sèvis gratis pou ede w nan lang ou pale a. Rele nan 1-877-605-3229 (moun ki itilize sistèm TTY rele : 711)

ATTENTION : si vous êtes locuteurs francophones, le service d'assistance linguistique gratuit est disponible. Appelez au 1-877-605-3229 (TTY : 711)

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń: 1-877-605-3229 (obsługa TTY: 711)

ATENÇÃO: Caso fale português, estão disponíveis serviços gratuitos de ajuda linguística. Telefone para 1-877-605-3229 (TERMINAL: 711)

ATTENZIONE: Se parla italiano, sono disponibili per lei servizi gratuiti di assistenza linguistica. Chiamare il numero 1-877-605-3229 (TTY: 711)

注意：日本語をご希望の方には、日本語サービスを無料で提供しております。1-877-605-3229（TTY、テレタイプライターをご利用の方は711）までお電話ください。

Achtung: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzdienste zur Verfügung. Rufen sie 1-877-605-3229 (TTY: 711)

توجه: در صورتی که به فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما موجود است. با 1-877-605-3229 (TTY: 711) تماس بگیرید.

УВАГА! Якщо ви говорите українською, для вас доступні безкоштовні консультації рідною мовою. Зателефонуйте 1-877-605-3229 (TTY: 711)

ATENȚIE: Dacă vorbiți limba română, vă punem la dispoziție serviciul de asistență lingvistică în mod gratuit. Sunați la 1-877-605-3229 (TTY 711)

THOV CEEB TOOM: Yog hais tias koj hais lus Hmoob, muaj cov kev pab cuam txhais lus, pub dawb rau koj. Hu rau 1-877-605-3229 (TTY: 711)

โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โทร 1-877-605-3229 (TTY: 711)

ត្រូវចងចាំ៖ បើអ្នកនិយាយភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដោយឥតគិតថ្លៃ គឺមានផ្តល់ជូនលោកអ្នក។ សូមទូរស័ព្ទទៅកាន់លេខ 1-877-605-3229 (TTY: 711)

HUBACHIISA: Yoo afaan Kshtik kan dubbattan ta'e tajaajiloonni gargaarsaa isiniif jira 1-877-605-3229(TTY:711) tiin bilbilaa.

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