



# Regence

Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueCross BlueShield of Utah  
2890 E. Cottonwood Parkway  
PO Box 30270  
Salt Lake City, Utah 84130-0270

## Group Master Application for Administrative Services Contract

This Group Master Application for Administrative Services Contract(GMA-ASC) collects information necessary to the preparation of a binding Administrative Services Contract (ASC) between Regence BlueCross BlueShield of Utah (Regence) and the following Plan Sponsor and Group Health Plan. The resulting ASC will describe the administrative services to be provided by Regence, the terms and conditions of their provision, and the respective responsibilities of each of the parties. Once executed by all parties, the ASC will prevail in the event of any conflict between its terms, conditions, and content and any information provided on, or provision of, this GMA-ASC or any term, condition, or element of the sample ASC affixed to this GMA-ASC.

This GMA-ASC also provides information for Regence's use in commencing the programming and the system and process design related to the contemplated administration of the Group Health Plan.

Requested Effective Date \_\_\_\_\_

SECTION A - GROUP INFORMATION			
Group Health Plan Name		Group Number	
Employer Legal Name (Plan Sponsor)	Doing Business As (DBA)	Name to be used by Regence <input type="checkbox"/> Legal <input type="checkbox"/> DBA	
Employer Federal (EIN) and State (if applicable) Tax ID Numbers		Location of Business Headquarters	
SIC Code and Industry Description 		Company Structure <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other _____	
Name and Title of President, Owner, CEO		Group's Primary Language (if other than English)	
Physical Business Address <b>Required</b> (No PO Box or PMB)		Mailing Address (if different from Physical Business Address)	
County	Phone Number ( ) Fax Number ( )	County	Phone Number ( ) Fax Number ( )
PRIMARY GROUP CONTACT			
Name (First, MI, Last)		Title	
Phone Number ( )	Fax Number ( )	E-mail Address	
PLAN ADMINISTRATOR (if different from primary contact)			
Name (First, MI, Last) or Name of Committee or Board		Title	
Phone Number ( )	Fax Number ( )	E-mail Address	



**SECTION A - GROUP INFORMATION (continued)****BILLING - ADMINISTRATIVE**Do you require separate billing invoices?  No  Yes **(If yes, please complete Additional Billing section below)**

Business Name	Contact and Title (if different than primary group contact)
Billing Address	Phone Number (        ) Fax Number (        )

**Payment Type**  
 Pay by Check  Wire Transfer  Surepay (EFT) **\*Please submit Surepay document**

<b>Additional Billing</b> Business Name	Contact and Title (if different than primary group contact)
Billing Address	Phone Number (        ) Fax Number (        )

**Payment Type**  
 Pay by Check  Wire Transfer  Surepay (EFT) **\*Please submit Surepay document****BILLING - CLAIMS**Do you require separate billing invoices?  No  Yes **(If yes, please complete Additional Billing section below)**Type of Invoice:  Summary  Detail      Hardcopy requested?  No  Yes

Business Name	Contact and Title (if different than primary group contact)
Billing Address	Phone Number (        ) Fax Number (        )

**Payment Type**  
 Wire Transfer  Weekly  Monthly

<b>Additional Billing</b> Business Name	Contact and Title (if different than primary group contact)
Billing Address	Phone Number (        ) Fax Number (        )

**Payment Type**  
 Wire Transfer  Weekly  Monthly**EMPLOYER CENTER**Employer Based Reporting  No  Yes\*      Online Enrollment and eBilling  No  Yes\*

<b>*Primary Group Administrator for Employer Center:</b> Name (First, MI, Last)	E-mail Address	Phone Number (        )
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If more than two Secondary Group Administrators for Employer Center are required, indicate the number desired \_\_\_\_\_

How does the group want employer reporting broken out by (i.e. locations, classes, sections, etc.)?



**SECTION B - PRODUCER (AGENT) INFORMATION**

Agency Name	Producer's E-mail Address	
Producer's Name	Producer's Phone Number (       )	Producer's Number
Secondary Producer's Name	Secondary Producer's Phone Number (       )	Secondary Producer's Number
Producer's Medical and/or Pharmacy Commission: <input type="checkbox"/> PEPM \$ _____ <input type="checkbox"/> PMPM \$ _____ <input type="checkbox"/> None		Commission Split %: Producer #1 _____%    Producer #2 _____%
Producer's Dental Commission: <input type="checkbox"/> PEPM \$ _____ <input type="checkbox"/> PMPM \$ _____ <input type="checkbox"/> None		Commission Split %: Producer #1 _____%    Producer #2 _____%
Additional Information:		

**SECTION C - FEDERAL MANDATES**

**COBRA:**  
 Group subject to COBRA?  No  Yes  
 COBRA applies to employer groups that have employed 20 or more employees for 50% or more of the typical business days in the preceding calendar year (January - December), with the exception of federal government plans and church plans. To the degree permitted by those laws, part-time employees may be counted as a fraction of a full-time employee.

**OBRA:**  
 Group subject to OBRA?  No  Yes  
 If you employed 100 or more full-time and/or part-time employees for at least 50% of the workdays of the preceding calendar year (January - December) you are subject to federal OBRA 1989/OBRA 1993 laws.

**TEFRA/DEFRA:**  
 Group subject to TEFRA/DEFRA?  No  Yes  
 If the TEFRA/DEFRA status has changed within the past year, please indicate the Date of Change \_\_\_\_\_  
 If you employed 20 or more full-time and/or part-time employees during each of 20 calendar weeks in the current or preceding calendar year (January - December) you are subject to federal TEFRA/DEFRA laws.

**ERISA:**  
 Group subject to ERISA?  No  Yes  
 Is your plan year different than your renewal date?  No  Yes, list date \_\_\_\_\_  
 Virtually all health plans of employers of any size (except church entities and government entities) are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA). This federal law sets minimum standards for the protection of individuals covered by a health plan subject to ERISA, as well as most voluntarily established pension plans.  
 ERISA Plan Note: If you use the benefit booklet as a component of the summary plan description and want to investigate meeting your distribution requirement electronically, see 29 CFR §2520.104b-1(c) for the U.S. Department of Labor's electronic distribution safe harbor.

**Schedule A & C / 5500:**  
 Per section 104 of ERISA, your group may be required to file IRS Form 5500 (Schedule A & C).  
 Do you require information from us to help you complete your Schedule A & C / Form 5500?  No  Yes  
 If yes, this information will be provided based on your insurance contract period.

**New Groups Only - Affordable Care Act Required Information:**  
 Please enter the average number of employees that were employed by your company during the prior calendar year (January - December) \_\_\_\_\_ .  
 This count should include: full-time, part-time, seasonal, and union employees that work inside or outside the state of Utah and employees in any state from any affiliated company. Remember to include business owners, corporate officers, and partners if they are also employees.



**SECTION D - OTHER CARRIER INFORMATION**

1. Does your group have current medical/dental/pharmacy benefits?
- Medical:**  No  Yes If yes, name of carrier \_\_\_\_\_ End date \_\_\_\_\_  
 If yes, is the plan insured or self-insured?  Insured  Self-insured
- Dental:**  No  Yes If yes, name of carrier \_\_\_\_\_ End date \_\_\_\_\_  
 If yes, is the plan insured or self-insured?  Insured  Self-insured
- Pharmacy:**  No  Yes If yes, name of carrier \_\_\_\_\_ End date \_\_\_\_\_  
 If yes, is the plan insured or self-insured?  Insured  Self-insured
- Will you be offering more than one medical/dental carrier to your employees?
2. **Medical:**  No  Yes\* If so and if any of your plan is insured, name of carrier(s) \_\_\_\_\_  
**Dental:**  No  Yes\* If so and if any of your plan is insured, name of carrier(s) \_\_\_\_\_  
**\*This option is not allowed in all instances.**
3. Does your group have Workers' Compensation coverage?  
 No  Yes If yes, name of carrier \_\_\_\_\_

**SECTION E - GROUP ELIGIBILITY (for purposes of determining group classification)**

**Note:** An "eligible employee" is defined as an employee who on a full-time basis worked 30 or more hours/week in the preceding calendar year.

1. Number of eligible employees in the preceding calendar year \_\_\_\_\_
2. Is the group a subsidiary or affiliate of another company?  No  Yes  
 If yes, please explain \_\_\_\_\_
3. Do you have eligible employees employed outside the State?  No  Yes If yes, please indicate below  
**Note:** Group members who reside in the state of Hawaii are not eligible for coverage.

Number of Employees Out of State	State 1	State 2	State 3	State 4	State 5	State 6
State						
Employee Count						

**SECTION F - EMPLOYEE ELIGIBILITY (for purposes of determining who is eligible for group benefits)**

**Note:** The minimum number of hours worked for eligibility are 30 hours in a normal work week.

1. This plan covers employees working the minimum number of hours required for coverage.  
 The minimum number of hours to be eligible for coverage are \_\_\_\_\_
2. This plan provides domestic partner coverage:  No  Yes
3. Probationary Periods:  
 Groups may list employees in different classifications (e.g. hourly, salaried) for the purpose of offering different probationary periods to each employee classification. If you have chosen to do this, describe each job classification below.  
**All employees must be accounted for.** (If there are no classes, please enter all information in space provided for Class 1).

	Actual Date of Hire	Coverage is effective on the first of the month following (please place an X in the appropriate box below)							
		Date of Hire (see 3A below)*	30 Days	60 Days	90 Days	120 Days	180 Days	365 Days	Other
Class 1:									
Class 2:									
Class 3:									

Additional Comments \_\_\_\_\_

- 3A. \*Choose how Date of Hire (DOH) Probationary Period will be administered:  
 Effective date will always be 1st of the month following DOH, even if DOH is the 1st of the month.  
 Effective date will be 1st of the month following DOH, with the exception of when the DOH is the 1st of the month.
- 3B. Is probationary period waived on group's initial enrollment:  No  Yes



**SECTION G - EMPLOYER CONTRIBUTION**

The employer will pay the following percentages/dollars toward the monthly rate. If different classes are chosen, please indicate classes and contribution for each.

**Note:** Employer must contribute a minimum of 75% of the employee rate for insurance or 50% of the total cost of premium. There is no minimum employer contribution percentage for dependents.

	Class 1		Class 2		Class 3	
	Medical and/or Pharmacy	Dental	Medical and/or Pharmacy	Dental	Medical and/or Pharmacy	Dental
Employee	% or \$	% or \$	% or \$	% or \$	% or \$	% or \$
Dependent	% or \$	% or \$	% or \$	% or \$	% or \$	% or \$

**SECTION H - GROUP PARTICIPATION**

**Participation Requirements:** There is a minimum participation requirement of 75% of eligible employees (line 5 below) after consideration of valid waivers, however, if the employer contributes 100% of the employee premium, we require 100% participation of eligible employees (line 5 below) after consideration of valid waivers.

1. Total number of employees on payroll regardless of hours worked (Do not include individuals participating on COBRA).....	+	_____
2. Less individuals not eligible for coverage on this plan (account for each of these individuals in one of the following that best applies):		
a) Number of employees working fewer than the minimum hours (as selected in Section F - Employee Eligibility).....	-	_____
b) Number of employees who are fulfilling their New Hire Probationary Period (as selected in Section F - Employee Eligibility).....	-	_____
c) Number of employees who are seasonal, substitute or temporary.....	-	_____
d) Number of individuals who are paid solely via IRS Form 1099.....	-	_____
e) Number of employees whose class is ineligible for coverage under this plan. Please enter the description of your group's ineligible class _____, if union, please provide a copy of the union roster.....	-	_____
3. Equals sub-total number of employees eligible to enroll.....	=	_____

Using the number of employees eligible to enroll (from line 3 above), continue for each type of coverage (Medical/Dental) elected:	Medical	Dental
4. Less number of employees who are waiving for <b>other qualifying coverage</b> .....	-	-
5. Equals total number of employees eligible to enroll.....	=	=
6. Less number of employees who are <b>declining coverage. (No other qualifying coverage)</b> .....	-	-
7. Equals number of employee applications submitted ( <b>new groups</b> ) / number of employees on coverage on the effective date ( <b>renewing groups</b> ).....	=	=
8. Employees participation percentage (line 7 divided by line 5).....	%	%
9. Number of subscribers and/or their dependents covered by your group under COBRA.....		
10. Number of former and current employees and/or their dependents who are currently eligible for COBRA but have not yet applied.....		



## SECTION I - ACKNOWLEDGMENTS AND CERTIFICATIONS

I am duly authorized to complete and submit this GMA-ASC on behalf of the Group Health Plan and/or Plan Sponsor as indicated below, and all statements made and information provided herein are accurate and complete to the best of my knowledge and belief. I acknowledge that Regence will rely in part upon the information in this GMA-ASC as the basis for its decision whether to enter the contemplated administrative services arrangement, will rely upon it to begin preparations for providing the service of that arrangement, and, if an ASC has not been finalized by the Requested Effective Date hereof, may rely upon it to begin providing administrative services as described below. If any of the information provided in this ASC should change before the finalization of the ASC with Regence, I agree to provide that updated information to Regence promptly after the change. Further, on behalf of the Group Health Plan and/or Plan sponsor, I:

- a) Acknowledge that eligibility standards (e.g., waiting period, minimum hours, etc.) must be established at the time of initial application, may be changed only at contract renewal, and must be adhered to for all employees and dependents.
- b) Agree to make payroll and other records directly related to employee participation levels or to employees' coverage, premiums, or contributions under the group contract(s) available to Regence for inspection. This provision shall survive the termination of the group contract(s). Upon renewal or anytime throughout the contract period, the Company agrees to provide Regence, upon its request, verifications of employee participation levels.
- c) Agree that, except with regard to a statutory continuation of coverage or unless the change is approved in writing by an authorized representative of Regence, at no time shall any employee be permitted or required to make contributions for coverage at a rate higher than the employee contribution rate represented herein.
- d) Appoint the agent of record indicated in Section B - Producer (Agent) Information (if any) to represent it in matters of group coverage benefits provided by Regence. This appointment is in effect on the same day as the group coverage(s) and remains in force until rescinded in writing.
- e) Acknowledge that, if the Company has an agent, that agent may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation from Regence. Incentives may be based on any of several factors, including the size of the Company's business, the products that the Company purchases, the agent's volume of business with Regence, and other services the agent provides to the Company. These incentives may have an indirect impact on the Company's rates. For more information, please contact the agent for the Company.

I agree that, if an ASC has not been fully executed before the Requested Effective Date specified herein, Regence may choose (by providing written notice to Plan Sponsor and Group Health Plan, and unless Plan Sponsor and/or Group Health Plan decline in writing within 3 days of such notice) to regard this GMA-ASC as an agreement in principle and to begin administration in accordance with the information provided in this GMA-ASC and, except as described below, in accordance with the terms, conditions, and other elements of the sample ASC affixed hereto until a fully executed ASC has been finalized by the parties. During any such period that Regence provides administration before finalization of ASC:

- a) Regence will administer the benefits described in this GMA-ASC and, in the event of conflict, those benefits shall take precedence over the benefits described in the Group Health Plan's most current summary plan description or benefit booklet (whether or not that summary plan description or benefit booklet has been provided to Regence);
- b) Plan Sponsor will pay Regence the administrative and other fees set forth in the attached fee schedule and those fees may be adjusted for any of the reasons set out in the sample ASC;
- c) Plan Sponsor will pay Regence the amount of each Weekly Claims Call within two (2) days of Regence's communication of the amount owed;
- d) Regence will not provide any nonstandard reports to Plan Sponsor or Group Health Plan;
- e) The fixed percentage of subrogation and right of reimbursement recoveries withheld by Regence to cover its costs of pursuit will be thirty percent (30%);



**SECTION I - ACKNOWLEDGMENTS AND CERTIFICATIONS (continued)**

- f) The late fee for administrative fees, claims or other invoices that are not paid to Regence by the due date will be 3% per month;
- g) Plan Sponsor and Group Health Plan will have no audit rights referenced in the sample ASC;
- h) Regence will not provide Run-out Claims Processing for the Group Health Plan if the negotiations for an ASC are terminated without an ASC being executed; and
- i) Regence may cease providing administration at anytime before ASC is executed.

In the event that Regence does commence providing administrative services before the parties finalize the ASC, Regence will have no obligation upon finalization of the ASC to revise or modify the services that it has already provided, except as expressly agreed in writing among the parties.

WE'VE GONE GREEN! To be more environmentally conscious and in response to employer requests, we will attach one paper copy of the booklet (unless another quantity has been previously arranged) describing your plans benefits to your contract. Inform your plan participants that they can access the booklet electronically at myRegence.com. Or, if preferred, you can contact your sales representative to order additional paper copies for distribution or can have any requesting plan participant request a paper copy by contacting customer service.

**SIGNATURES**

**GROUP HEALTH PLAN**

Authorized Signature ▶ \_\_\_\_\_

Title ▶ \_\_\_\_\_

Date ▶ \_\_\_\_\_

**PLAN SPONSOR**

Authorized Signature ▶ \_\_\_\_\_

Title ▶ \_\_\_\_\_

Date ▶ \_\_\_\_\_

