PROVIDENCE Health Plan

# Oregon Small Group
# MASTER CONTRACT APPLICATION
2020 Contract Year

Date _____

Legal name _____ Industry Type _____

DBA _____ NAICS Code _____
(Enter if different than legal name)

Requested effective date _____

Previous Providence Health Plan group? ☐ Yes ☐ No If yes, previous PHP group # _____

Contract contact _____

Mailing address:

_____

City _____ State, ZIP _____

Phone# _____ Fax# _____

Email address _____

Physical address:

_____

City _____ State, ZIP _____

County _____

Billing contact _____

Billing address:

_____

City _____ State, ZIP _____

Email address _____

Business Fed Tax ID # (required) _____

CMS group size* _____

***CMS group size definition**: The Centers for Medicare & Medicaid Services determine group size as the current total number of nationwide full-time employees, part-time employees, seasonal employees and partners. Do not count retirees, COBRA-qualified beneficiaries, individuals on other continuation options, or self-employed individuals who participate in the employer's group health plan.

Subject to ☐ COBRA **or** ☐ State continuation

***Dependents or students eligible to age 26.***

Minimum hours required per week (17.5 or more) _____

Number of Benefit Eligible Employees _____

☐ Employee-only contract*
*By checking this box dependents are ineligible to enroll during the 12 month contract

The employer must contribute a minimum of 50% to the employee only rate of the least expensive plan offered to employees as required by law.

**New Hire Eligibility**

☐ First of the month following: ☐ 30 days ☐ 60 days ☐ Date of hire

☐ First of the month following date of hire. If hired on the first of the month, coverage is effective that day.

☐ Day immediately following: ☐ 30 days ☐ 60 days ☐ 90 days

☐ Date of hire

Waive probationary period at initial enrollment? ☐ Yes ☐ No

Previous carrier _____ Previous group # _____

Remarks: _____


Portland office: PO Box 4327
Portland, OR 97208-4327
Phone: 1-877-245-4077
Fax: 503-574-7543

Eugene office: 1500 Valley River Drive, Suite 200
Eugene, OR 97401
Phone: 1-877-245-4077
Fax: 800-889-8218

## OREGON SMALL GROUP PLAN OPTIONS

| Total Enhanced |
|---|
| ☐ Total Enhanced 250 Platinum |
| ☐ Total Enhanced 500 Platinum |
| ☐ Total Enhanced 1000 Gold |
| ☐ Total Enhanced 1500 Gold |
| ☐ Total Enhanced 2500 Gold |
| ☐ Total Enhanced 3500 Gold |
| ☐ Total Enhanced 4500 Gold |
| ☐ Total Enhanced 5500 Gold |
| ☐ Total Enhanced 7000 Silver |

| Balance |
|---|
| ☐ Balance 750 Gold |
| ☐ Balance 1500 Gold |
| ☐ Balance 2500 Silver |
| ☐ Balance 3500 Silver |
| ☐ Balance 4500 Silver |
| ☐ Balance 6000 Silver |
| ☐ Balance 7000 Bronze |
| ☐ Balance 8150 Bronze |

| Standard* *Indicate YES or NO: applying for Marketplace* | | |
|---|---|---|
| ☐ Providence Oregon Standard Gold | ☐ Yes | ☐ No |
| ☐ Providence Oregon Standard Silver | ☐ Yes | ☐ No |
| ☐ Providence Oregon Standard Bronze | ☐ Yes | ☐ No |

| Connect |
|---|
| ☐ Connect 750 Gold |
| ☐ Connect 1500 Gold |
| ☐ Connect 2500 Silver |
| ☐ Connect 3500 Silver |
| ☐ Connect 4500 Silver |
| ☐ Connect 6000 Silver |
| ☐ Connect 7000 Bronze |
| ☐ Connect 8150 Bronze |

| HSA Qualified |
|---|
| ☐ HSA Qualified 2000 Silver |
| ☐ HSA Qualified 2500 Silver |
| ☐ HSA Qualified 3500 Silver |
| ☐ HSA Qualified 4500 Bronze |
| ☐ HSA Qualified 5500 Bronze |
| ☐ HSA Qualified 6750 Bronze |

| Dental *Dental enrollment & eligibility must match medical enrollment* |
|---|
| ☐ Providence Essential Dental |
| ☐ Providence Essential Access Dental |
| ☐ Providence Advantage Access Dental |
| ☐ Providence Preventive Dental |

| Domestic Partner |
|---|
| ☐ Domestic Partner Plus |

| CDHP Accounts – The following integrated accounts are serviced by HealthEquity | |
|---|---|
| ☐ Health Savings Account (HSA)<br>*Can be paired with any HSA Qualified plan* | ☐ Flexible Spending Account (FSA)<br>*Can be paired with any non-HSA plan* |
| ☐ Health Reimbursement Account (HRA)<br>*Can be paired with any non-HSA plan* | ☐ Limited Purpose Flexible Spending Account (LPFSA)<br>*Can be paired with a HSA for dental and vision care* |

***Pediatric Dental Disclaimer:** Some of our medical plan options DO NOT include pediatric dental coverage. Under the healthcare reform law (the Affordable Care Act or ACA), if you purchase our medical coverage outside of the Exchange, we must have reasonable assurance that you have obtained separate pediatric dental coverage through an Exchange-certified pediatric dental plan. This requirement applies whether you obtain coverage for children or adults. Exchange-certified pediatric dental plans can be found through the Federally Facilitated Marketplace, www.healthcare.gov. If you purchase a PHP Standard medical plan, adding the Providence Dental Plan for children aged 18 and younger does not satisfy the ACA pediatric dental Essential Health Benefit (EHB) requirement.

**PROVIDENCE USE ONLY**

| | Medical Premium Totals | | | | Dental Premium Totals |
|---|---|---|---|---|---|
| Tier | Plan 1 | Plan 2 | Plan 3 | Tier | |
| S | | | | S | |
| SS | | | | SS | |
| SC | | | | SC | |
| SSC | | | | SSC | |

| | | | | | |
|---|---|---|---|---|---|
| Account Executive | | Check $ | | Eligible | |
| Service Specialist | | Check # | | Subscribers | |
| Group # | | Total Premium $ | | Members | |


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## PRODUCER INFORMATION

Producer_____Commission schedule *applies to medical & dental* = PMPM

Firm_____ Phone_____ Producer#_____

Full address _____

Original contract will be mailed to the group; a copy will be mailed to the Producer.

## PRODUCER STATEMENT

I certify that all the information contained in this application is correct to the best of my knowledge. I also certify that:

1. This firm is a bona fide business meeting the definition of Oregon Small Employer and/or a small employer as defined by HIPAA and complies with Providence Health Plan underwriting requirements for small employers.
2. All participation requirements have been met.
3. Coverage(s), enrollment provisions, eligibility requirements, benefits, limitations, and exclusions have been fully explained and understood by the employer.

Dated this_____day of_____, 20_____

Print name and title

Producer signature

## EMPLOYER STATEMENT

1. We wish to apply to enroll our firm as a group with Providence Health Plan. We understand payment of premium will be deemed to be assent to all terms of the group contract, including modifications and renewals that are sent to us.
2. We understand that the final rates will be based on actual enrollment and may be different than the rates originally quoted.
3. Minimum participation requirements for specific coverage(s) have been fully explained in detail, and we understand that they must be met and maintained in order for the group to remain eligible for coverage.
4. We understand the obligation to provide the Summary of Benefits and Coverage (SBC) to eligible employees at open enrollment and when newly eligible or newly hired, as required by the Patient Protection and Affordable Care Act and related regulations and rules, and accept responsibility for delivering the document.
5. We affirm that if we choose a medical plan without pediatric dental coverage, we will obtain pediatric dental coverage, as required by federal law, and that we will notify Providence Health Plan if we do not obtain coverage.
6. The broker/producer stated above is our Producer of record for Providence Health Plan and will remain such until this application is rescinded in writing.
7. To the best of our knowledge and belief, the foregoing statements are true and complete and, along with the group application, shall be the basis for the issuance of coverage under the group policy and shall become part thereof.
8. We understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company; and such intent to defraud may be subject to criminal and civil penalties and Providence Health Plan may cancel the group account and refuse to pay claims.
9. We understand that 30 days' notice is required to change this agreement.
10. We affirm that we are contributing a minimum of 50% of the employee only rate of the least expensive plan offered to employees, as required by law.

Dated this_____day of_____, 20_____

Print name and title

Authorized group signature


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