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Blue Cross Blue Shield of North Dakota is an independent licensee of the  
Blue Cross Blue Shield Association

Blue Cross Blue Shield of North Dakota (BCBSND)  
Return form to: BCBSND Representative

## Group Master Application – for Administrative Services Contract

This document collects information necessary for BCBSND to administer the Plan Sponsor(s) self-funded group health plan. Capitalized terms used but not defined herein shall have the meanings as defined or used in the Agreement.

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

Group Number 

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|

### SECTION A – GROUP NAME & ADDRESS

Group's Legal Name:  
(should match the full legal name used on state business registry)

Plan Sponsor(s) Name:

Group Health Plan Name:

Is the group Doing Business As (DBA) another name? ☐ No ☐ Yes – If yes, enter DBA name below:

Name to be used by BCBSND: ☐ Legal ☐ DBA

City of Business Headquarters

State of Business Headquarters

Federal Tax ID Number (EIN)

#### Address (physical address required)

Physical Address (no PO Box or Private Mailbox)

City

County

State

ZIP

Mailing Address (if different from physical)

City

County

State

ZIP

### SECTION B – CONTACT INFORMATION

#### 1. Executive Contact (President, Owner, etc.)

Name Phone (area code required)  
Ext.

Title Email

#### 2. Group Administrator

Name Phone (area code required)  
Ext.

Title Email

**3. Employer Center –** Access group information any time using the Employer Center online portal. Provide contact information for the primary Employer Center user account below. **If selecting BCBSND Online Enrollment, digital invoices, or to set up ACH Pull payment options, access to Employer Center is required.** An email will be sent to this user with registration instructions once the group setup is complete. Once the Primary user is set up, they can appoint secondary users directly through Employer Center.\*

\*The Primary Employer Center contact may not be a producer or employee of a producer.

Primary User Name Phone (area code required)  
Ext. Email

If applicable, should Employer Based Reporting through BCBSND TrendWise be granted to this Employer Center user?

☐ No ☐ Yes



**SECTION C – BILLING INFORMATION**

**1. Administrative Billing Information** – If you have more than one billing location/subgroup, submit that billing information on a separate page.

|                                             |        |      |                                                      |  |      |
|---------------------------------------------|--------|------|------------------------------------------------------|--|------|
| Billing Address (if different from mailing) |        |      | Contact Name (if different from group administrator) |  |      |
|                                             |        |      | Title:                                               |  |      |
|                                             |        |      | Phone (area code required):                          |  | Ext. |
| City:                                       | State: | ZIP: | Email:                                               |  |      |

Payment Method:

☐ ACH Pull ☐ ACH Push (an advance deposit is required) ☐ Wire (an advance deposit may be required)

**2. Claims Billing Information** – The payment for claims billing is processed via ACH Pull. Please submit a completed Authorization Agreement for Electronic Remittance with this form.

**3. Third Party Administrator** – Complete only if a Third Party Administrator (TPA) is used.

|           |        |      |                             |  |      |
|-----------|--------|------|-----------------------------|--|------|
| TPA Name: |        |      |                             |  |      |
| Address   |        |      | Contact Name:               |  |      |
|           |        |      | Title:                      |  |      |
|           |        |      | Phone (area code required): |  | Ext. |
| City:     | State: | ZIP: | Email:                      |  |      |

Does the group use this TPA for COBRA administration? ☐ No ☐ Yes

If yes: Will the TPA submit COBRA enrollment/disenrollment directly to BCBSND? ☐ No ☐ Yes

Will invoices for COBRA participants go to the TPA address listed? ☐ No ☐ Yes

**SECTION D – CONSULTANT INFORMATION****1. Primary Consultant**

|                                                                                          |                     |                          |
|------------------------------------------------------------------------------------------|---------------------|--------------------------|
| Consultant's Name                                                                        | Consultant's Agency | National Producer Number |
| Medical Commission: <input type="checkbox"/> PEPM \$ _____ <input type="checkbox"/> None |                     |                          |
| Dental Commission: <input type="checkbox"/> PEPM \$ _____ <input type="checkbox"/> None  |                     |                          |

**2. Secondary Consultant**

|                                                                                     |                     |                          |
|-------------------------------------------------------------------------------------|---------------------|--------------------------|
| Consultant's Name                                                                   | Consultant's Agency | National Producer Number |
| Commission Split – Medical: Primary Consultant: _____% Secondary Consultant: _____% |                     |                          |
| Commission Split – Dental: Primary Consultant: _____% Secondary Consultant: _____%  |                     |                          |

**SECTION E – GROUP INFORMATION****1. General Information**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                      |                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-----------------------|
| SIC Code                                                                                                                                                                                                                                                                                                                                                                                                                                            | Industry Description | Date Business Started |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                      |                       |
| Type of Business (if LLC, please choose the option that matches how the business files with the IRS):<br><input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> S-Corp <input type="checkbox"/> C-Corp <input type="checkbox"/> Other: _____                                                                                                                                                    |                      |                       |
| Does the group have any affiliated businesses or is the group part of an affiliated service group as defined under section 414 of the Internal Revenue Code? Affiliated businesses may include parent-subsidiary, brother-sister, or the combination of such affiliations that constitute a control group under the Internal Revenue Code. <input type="checkbox"/> No <input type="checkbox"/> Yes – Enter name(s) of affiliated businesses: _____ |                      |                       |



**SECTION E – GROUP INFORMATION (continued)****2. Other Carrier/Claims Administrator Information**Does the group have current **Medical** benefits?

☐ No ☐ Yes, name of carrier/claims administrator: \_\_\_\_\_ End Date: \_\_\_\_\_  
If yes, is the plan insured or self-insured? ☐ Insured ☐ Self-insured

Does the group have current **Pharmacy** benefits?

☐ No ☐ Yes, name of carrier/claims administrator: \_\_\_\_\_ End Date: \_\_\_\_\_  
If yes, is the plan insured or self-insured? ☐ Insured ☐ Self-insured

Does the group have current **Dental** benefits?

☐ No ☐ Yes, name of carrier/claims administrator: \_\_\_\_\_ End Date: \_\_\_\_\_  
If yes, is the plan insured or self-insured? ☐ Insured ☐ Self-insured

Will the group offer other medical or dental coverage to its eligible employees? (Not allowed in all instances.)

Medical: ☐ No ☐ Yes – If yes, name of carrier(s)/claims administrator(s): \_\_\_\_\_  
Dental: ☐ No ☐ Yes – If yes, name of carrier(s)/claims administrator(s): \_\_\_\_\_

**3. Deductible and Out of Pocket Accumulators** – To credit amounts accumulated from the prior carrier, confirm whether amounts were accumulated on the basis of a calendar year (January - December) or a plan year (matching your contract renewal period e.g., renewal month is April, accumulation starts April 1 and ends March 31).

Under the prior carrier/claims administrator, deductible and out of pocket amounts accumulated on the basis of a:

☐ calendar year.  
☐ plan year. Enter dates for the plan year accumulators with prior carrier/claims administrator: \_\_\_\_\_  
☐ not applicable (no prior group policy)

**4. COBRA** – Applies if group employed 20 or more employees for 50% or more of the typical business days in the preceding calendar year (excluding church and federal government groups). You may count a part-time employee as a fraction of a full-time employee.

Is the group subject to COBRA? ☐ No ☐ Yes

**5. ERISA** – Generally, ERISA applies to most self-funded group health plans, except for church and government entities.

Is the group subject to ERISA? ☐ No ☐ YesIf yes, does ERISA plan year differ from your renewal date? ☐ No ☐ Yes, when does the plan year begin (MM/DD): \_\_\_\_\_

Do you require information from us to help you complete your Schedule A &amp; C/Form 5500?

☐ No ☐ Yes – If yes, this information will be provided based on your ASC contract period.

**6. OBRA** – Applies if group employed 100 or more employees (full-time and/or part-time) for at least 50% of the workdays of the preceding calendar year.

Is the group subject to OBRA? ☐ No ☐ Yes

**7. TEFRA/DEFRA** – Applies if group employed 20 or more employees (full-time and/or part-time) for each working day in each of 20 or more calendar weeks in the current or preceding calendar year.

Is the group subject to TEFRA/DEFRA? ☐ No ☐ Yes

If status has changed in the last year, date of change: \_\_\_\_\_

**8. Employee Counts – Group Size Determination**

Provide the number of eligible employees in the preceding calendar year: \_\_\_\_\_

**9. Employee Counts – Non-residents** – Count of eligible employees outside the state. Please be aware that there may be additional requirements for employees residing in the state of Hawaii.

|                     |  |  |  |  |  |
|---------------------|--|--|--|--|--|
| State               |  |  |  |  |  |
| Number of Employees |  |  |  |  |  |

**SECTION F – ADMINISTRATION**

**1. Eligibility** – Group level changes may only be made at renewal. ASC groups are responsible for administering eligibility per the terms of their contract. BCBSND will not administer a probationary period and groups should confer with their internal legal counsel.

Will the group include coverage for domestic partners? ☐ No ☐ Yes

**SECTION F – ADMINISTRATION (continued)**

List classes below (if one class, make selection on line 1)  
Class (account for all eligible employees, including retirees if applicable)

1  
2  
3

**2. Participation Information**

At the time of the application, the group represents that:

|                                                                                       |   |     |
|---------------------------------------------------------------------------------------|---|-----|
| A. Number of employees on payroll plus working owners (excluding COBRA participants*) |   | (A) |
| B. Minus individuals not eligible: working fewer than the minimum hours               | - | (B) |
| C. Minus individuals not eligible: still serving new-hire probationary period         | - | (C) |
| D. Minus individuals not eligible: seasonal, substitute or temporary                  | - | (D) |
| E. Minus individuals not eligible: contracted 1099 individuals                        | - | (E) |
| F. Equals the subtotal number of eligible employees                                   | = | (F) |

| Use subtotal (F) to continue calculations for Medical and Dental.                                                                           | Medical | Dental |
|---------------------------------------------------------------------------------------------------------------------------------------------|---------|--------|
| G. Minus employees waiving with other qualifying coverage                                                                                   | - (G)   | - (G)  |
| H. Equals number of employees eligible to enroll                                                                                            | = (H)   | = (H)  |
| I. Minus employees declining (no other qualifying coverage)                                                                                 | - (I)   | - (I)  |
| J. Equals number of employees enrolling                                                                                                     | = (J)   | = (J)  |
| K. Participation percentage (J divided by H)                                                                                                | %(K)    | %(K)   |
| L. Number enrolling on COBRA*                                                                                                               | (L)     | (L)    |
| M. Number of former and current employees and/or dependents presently eligible for COBRA* for whom election and payment is not yet received | (M)     | (M)    |

\*Refers to both COBRA and non-COBRA continuation of coverage participants.

Does the group offer an Individual Coverage Health Reimbursement Arrangement (ICHRA) to a class or classes of employees?  
☐ No ☐ Yes

**3. Enrollment Method**

☐ BCBSND Online Enrollment\* ☐ ANSI 834\*\* ☐ BCBSND Paper Enrollment Forms

\*If choosing "BCBSND Online Enrollment," will the group allow employees to enroll themselves? ☐ No ☐ Yes

\*\*If selecting ANSI 834 as your enrollment method, please provide your ANSI vendor's contact information to begin the process.

|             |              |
|-------------|--------------|
| Vendor Name | Vendor email |
|-------------|--------------|

**4. HealthEquity Integration with Savings and Reimbursement Accounts**

**Health Savings Account (HSA)** – Complete only if a BCBSND HSA-eligible healthplan will be offered. BCBSND offers integration with HealthEquity, an HSA Administrator. This integration allows HealthEquity to automatically set up health savings accounts for each employee enrolled on a BCBSND HSA-eligible healthplan who has chosen to participate.

Will the group elect HealthEquity to administer its health savings accounts?

☐ No ☐ Yes – Who will pay the monthly fee? ☐ Employer ☐ Employee

How do you intend to contribute to the employees' HSA accounts?

☐ Annual Seed ☐ Regular Contributions ☐ Payroll Match ☐ Combination Strategy ☐ No contribution

**Health Reimbursement Account (HRA)**

Will you be offering an HRA through HealthEquity? ☐ No ☐ Yes

If Yes, will you be offering an HRA to all classes? ☐ No ☐ Yes (if No, list applicable classes below.)

Classes: \_\_\_\_\_

Are you offering HRAs to all employees? (Separate classes may be needed if all employees are not offered an HRA) ☐ No ☐ Yes

**Flexible Spending Account (FSA)**

Will you offer your employees an FSA through HealthEquity? ☐ No ☐ Yes



## SECTION G – 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 information provided and statements made herein are accurate and complete to the best of my knowledge and belief. I acknowledge that BCBSND 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 BCBSND, I agree to provide that updated information to BCBSND 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, dependent eligibility, 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 BCBSND for inspection. This provision shall survive the termination of the group contract(s). Upon renewal or anytime throughout the contract period, the Plan Sponsor agrees to provide BCBSND, upon its request, verifications of employee participation levels.
- c) Delegate to the Consultant of record (if any) indicated in Section D – Consultant Information to represent it in matters of group coverage benefits provided by BCBSND. This appointment is in effect on the same day as the group coverage(s) and remains in force until rescinded in writing.
- d) Acknowledge that, if the Plan Sponsor has a consultant, that consultant may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation from BCBSND. Incentives may be based on any of several factors, including the size of the Plan Sponsor's business, the products that the Plan Sponsor purchases, the consultant's volume of business with BCBSND, and other services the consultant provides to the Plan Sponsor. These incentives may have an indirect impact on the Plan Sponsor's rates. For more information, please contact the consultant for the Plan Sponsor.

I agree that, if an ASC has not been fully executed before the Requested Effective Date specified herein, BCBSND 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 BCBSND provides administration before finalization of ASC:

- a) Plan Sponsor will pay BCBSND 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;
- b) Plan Sponsor will pay BCBSND the amount of each Weekly Claims Call within two (2) days of BCBSND's communication of the amount owed;
- c) BCBSND will not provide any nonstandard reports to Plan Sponsor or Group Health Plan;
- d) BCBSND will withhold a percentage of subrogation and right of reimbursement recoveries to cover its costs of pursuit. The percentage is listed in the proposal documents and ASC Fee Schedule Addendum;
- e) The late fees for all BCBSND invoices that are not paid by the due date will be assessed up to 1.5% per month;
- f) Plan Sponsor and Group Health Plan will have no audit rights referenced in the sample ASC, however, upon full execution of the ASC by all parties to the agreement, the audit rights in the fully-executed ASC will apply, including retroactively to the period from commencement of administration pursuant to the sample ASC through the full execution of the ASC;
- g) BCBSND 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;
- h) BCBSND may cease providing administration at any time before ASC is executed; and
- i) Acknowledges that BCBSND's statements in this application, including the descriptions of laws in Section E, are not legal advice and that the Plan Sponsor and Group Health Plan should look solely to their legal advisors with legal questions or concerns.
- j) Agrees to provide workers' compensation insurance to its employees as required by applicable law.

In the event that BCBSND does commence providing administrative services before the parties finalize the ASC, BCBSND 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.

**Blue Cross Blue Shield of North Dakota: 4510 13th Avenue South, Fargo, ND 58121**

