Group Health Cooperative
of South Central Wisconsin

APPLICATION FOR GROUP SERVICE AGREEMENT
(Small Group Non-ACA Transitional Plans)

GHC-SCW Administration • Attn: Sales, P.O. BOX 44971
Madison, WI 53744-4971 • Phone: (608) 251-3356

Application is hereby made to Group Health Cooperative of South Central Wisconsin (GHC-SCW) for renewal of a Group Service Agreement. This application provides the specifics for the Administration of the Group Service Agreement and is to be reviewed annually. *Please complete all of the blank areas and indicate any change by crossing through the current information and writing in the correct information to help us update our records.*

◯ Renewal Application ◯ Health
◯ Change of Status

EMPLOYER INFORMATION

Legal Name of Group	Corp. ID	SIC #	Federal Employer ID #
Street Address			City
State	Zip	Nature of Business	Total # of Employees on Payroll
# of Employees Eligible for Coverage in GHC-SCW Service Area	*Minimum Hours Worked to be Considered Eligible	Effective Date	Renewal Date

**Coverage must be offered to all employees who work 30 or more hours per week to meet WI law. GHC-SCW underwriting guidelines allow employers to select a minimum hourly requirement of no less than 20 hours and no more than 30 hours per week.*

◯ Renew same as previous year — *If checked, Eligibility, Termination and Plan Selection will remain the same.*

ELIGIBILITY

For renewal – Only complete if making change.

- *Any changes requested will become effective on your renewal date.*
- *Your employee's application must be received within 30 days after becoming eligible.*
- *If your employee <u>does not</u> enroll when eligible, he or she may be considered a late entrant and subject to a waiting period of up to 12 months.*

Check desired eligibility provision below

◯ Please check this box if you would like to have a 1-month orientation period prior to the beginning of the employee waiting period. If you would like this option, please check this box in addition to one of the eligibility provisions listed below.

The orientation period is measured by adding one calendar month and subtracting one calendar month from the employee's date of hire. *Here are some examples:*

- *If an employee is hired on June 5th, the employee's orientation period will end on July 4th, and the employee's waiting period will begin on July 5th.*
- *If an employee is hired on October 1st, the employee's orientation period will end on October 31st, and the employee's waiting period will begin on November 1st.*

Please note that a 1-month orientation period could result in the employer group being responsible for an Employer Shared Responsibility payment under IRS Code § 4980. Under IRS Code § 4980, certain large employers could be subject to penalty if they fail to give full-time employees the opportunity to enroll in coverage by the first day of the fourth month of employment.

◯ **(20)** Immediately on Date of Hire (DOH)
◯ **(21)** 1st Month from DOH
◯ **(22)** Immediately after 15 Days from DOH
◯ **(23)** 1st Month Following 15 Days from DOH
◯ **(24)** Immediately after 30 Days from DOH
◯ **(25)** 1st Mo. Following 30 Days from DOH
◯ **(26)** Immediately after 45 Days from DOH
◯ **(27)** 1st Month Following 45 Days from DOH
◯ **(28)** Immediately after 60 Days from DOH
◯ **(29)** 1st Month Following 60 Days from DOH
◯ **(30)** Other (please explain) _____

Is the eligibility period the same as listed above for employees in the following situations: *(applicant must meet group's eligibility period first before these provisions apply)*

Changing from Part-time to Full-time	◯ Yes	◯ No	*If no, please explain eligibility guidelines:* _____
Return from leave of absence	◯ Yes	◯ No	*If no, please explain eligibility guidelines:* _____
Return from Layoff	◯ Yes	◯ No	*If no, please explain eligibility guidelines:* _____
Rehire	◯ Yes	◯ No	*If no, please explain eligibility guidelines:* _____

Effective Date from 1st to 15th, Full Month Premium Due, Effective Date from 16th to 31st, Premium Waived for Balance of Month.

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TERMINATION *For renewal – Only complete if making change.*

New or Existing Group *Check desired termination provision below*

- ◯ **(A)** Last Day of Employment
  - *Date of Termination from 1st to 15th, No Premium Due for Month*
  - *Date of Termination from 16th to 31st, Full Month Premium Due*
- ◯ **(B)** Last Day of Coverage Month
  - *Full Premium Due Through End of Coverage Month*
- ◯ **(C)** 1st of Month Following One Month from Date of Termination
- ◯ **(D)** Other *(please explain)* _____

PLAN SELECTION *For renewal – only complete if making change*

- Plan numbers below allow you to access detailed Benefit Summaries and SBC's at ghcscw.com.
- Please check the plan(s) you are offering for the coming plan year.

Small Group Non-ACA Transition Plans

Plan Type	Plan Name	2023 Plan #	2024 Plan #	
HMO	$0 Co-payment Plan	2361501	2461501	◯
HMO	$10 Co-payment Plan	2361502	2461502	◯
HMO	$20 Co-payment Plan	2361503	2461503	◯
HMO	$30 Co-payment Plan	2361504	2461504	◯
HMO	$30 Co-payment Plan No Rx	2361505	2461505	◯
HMO	$20 Co-payment Plan with $100 ER Co-payment	2361506	2461506	◯
HMO	$30 Co-payment & $100 ER Copayment Plan	2361507	2461507	◯
HMO	$40 Co-payment with $100 ER Plan	2361508	2461508	◯
HMO	$500 Deductible $20 Co-payment Plan	2361509	2461509	◯
HMO	$500 Deductible Plan	2361510	2461510	◯
HMO	$1,000 Deductible $30 Co-payment Plan	2361511	2461511	◯
HMO	$1,000 Deductible Plan	2361512	2461512	◯
HMO	$1,500 Deductible Plan	2361513	2461513	◯
HMO	$2,000 Deductible $40 Co-payment Plan	2361514	2461514	◯
HMO	$2,000 Deductible Plan	2361515	2461515	◯
HMO	Consumer Driven $500 Deductible Plan	2361516	2461516	◯
HMO	Consumer Driven $1,000 Deductible $30 Co-payment Plan	2361517	2461517	◯
HMO	Consumer Driven $1,000 Deductible Plan	2361518	2461518	◯
HMO	Consumer Driven $1,500 Deductible Plan	2361519	2461519	◯
HMO	Consumer Driven $2,000 Deductible $40 Co-payment Plan	2361520	2461520	◯
HMO	Consumer Driven $2,000 Deductible Plan	2361521	2461521	◯
HMO	$1,600 High Deductible Health Plan - 0%	2361522	2461522	◯
HMO	$1,600 High Deductible Health Plan with Rx - 0%	2361523	2461523	◯
HMO	$1,600 High Deductible Health Plan with Rx - 20%	2361524	2461524	◯
HMO	$2,500 High Deductible Health Plan - 0%	2361525	2461525	◯
HMO	$2,500 High Deductible Health Plan with Rx - 0%	2361526	2461526	◯
HMO	$2,500 High Deductible Health Plan with Rx - 20%	2361527	2461527	◯
HMO	$5,250 High Deductible Health Plan - 0%	2361528	2461528	◯
HMO	$5,250 High Deductible Health Plan with Rx - 0%	2361529	2461529	◯
HMO	$20 Co-payment Plan	2361530	2461530	◯
HMO	$15 Co-payment Plan	2361531	2461531	◯
HMO	$1,600 High Deductible Health Plan - 20%	2361532	2461532	◯
PPO	$0 Deductible $10 Co-payment PPO Plan	2363501	2463501	◯
PPO	$0 Deductible $20 Co-payment PPO Plan	2363502	2463502	◯
PPO	$0 Deductible $30 Co-payment PPO Plan	2363503	2463503	◯
PPO	$500 Deductible, $20 Co-payment PPO Plan	2363504	2463504	◯
PPO	$500 Deductible 80/20 Co-insurance PPO Plan	2363505	2463505	◯
PPO	$1,000 Deductible, $30 Co-payment PPO Plan	2363506	2463506	◯
PPO	$1,000 Deductible 70/30 Co-insurance PPO Plan	2363507	2463507	◯
PPO	$2,000 Deductible, $40 Co-payment PPO Plan	2363508	2463508	◯
PPO	$1,500 Deductible 70/30 Co-insurance PPO Plan	2363509	2463509	◯
PPO	Consumer Driven $1,000 Deductible $30 Co-pay PPO Plan	2363510	2463510	◯
PPO	Consumer Driven $2,000 Deductible $40 Co-pay PPO Plan	2363511	2463511	◯
PPO	$1,600 PPO High Deductible Health Plan w/ Rx - 0%	2363512	2463512	◯
PPO	$1,600 PPO High Deductible Health Plan w/ Rx - 20%	2363513	2463513	◯
PPO	$2,500 PPO High Deductible Health Plan w/ Rx - 0%	2363514	2463514	◯
PPO	$2,500 PPO High Deductible Health Plan w/ Rx - 20%	2363515	2463515	◯

* Please consult the Member Certificate, Summary of Benefits and Coverage, Benefits Summary, Group Service Agreement and any applicable amendments for specific information regarding covered services, services that require Prior Authorization, and exclusions and limitations.

Optional Benefit/Amendments *For renewal – Only complete if making change.*

Domestic Partner Coverage *(Available at no extra cost. Subject to Eligibility Criteria)* ◯ No | ◯ Yes -

HRA ◯ No | ◯ Yes Vendor ◯ EBC ◯ TASC ◯ Other _____

Employer Contribution. Employers must contribute a minimum of 50% of the employee rate for all enrolled employees and at least the same dollar amount towards the other rates. If more than one health plan is offered, the employer may pay 50% of the employee rate of the least expensive plan.

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PREMIUMS ARE DUE BY THE 20TH OF THE MONTH FOR THE NEXT COVERAGE MONTH

ACCEPTANCE

All legal and tax questions concerning the Plan are the responsibility of the Employer. No service provided by the terms of this agreement will be construed as legal or tax advice or interpretation. The employer must rely on the opinions of its own tax or legal advisors, as it deems necessary or appropriate.
I agree and accept the benefit option(s) I have chosen.

Authorized Group Official

Date of Application	Signature
Printed Name	Title
Email	Phone and Fax