EMPLOYER APPLICATION
(True Group Application)

☐ New Business ☐ Renewal Business ☒ Other **Revised Eligibility Language for Loc. 01 - See Special Instructions** Group # (BCBSF): **30749** (HMO): **30749J**

I. Applicant Information

A. Name of Group: **NASSAU COUNTY BOCC**
Nature of Business: **Executive offices** SIC Code: **9111**
Mailing Address: **P.O. BOX 1010 FERNANDINA BCH, FL 32035-1010**
List below Subsidiary or Affiliated Companies whose employees are to be eligible and included with this application.
Name: ______ Address: ______

B. Applicant hereby applies for issuance of a Group Policy (herein referred to as Policy) by Blue Cross and Blue Shield of Florida, Inc. (BCBSF) and/or Health Options, Inc. (HOI). Upon acceptance of this application by BCBSF and/or HOI, it will become part of the Policy issued to the applicant named above.

C. Prior Health Carrier: Insurance **FLORIDA LEAGUE OF CITIES** (HMO) ______

D. The Policy excludes expenses for any service or supply to diagnose or treat any Condition resulting from or in connection with an Insured's job or employment (e.g., any service or supply which is covered by Workers' Compensation insurance) except for medically necessary services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual. The foregoing exclusion applies to an individual who elects exemption from Workers' Compensation coverage and to an individual who foregoes Workers' Compensation coverage available to employees in the Group.

E. Worker's Compensation carrier is **BITUMINOUS CASUALTY CORP.**

II. Effective Date / Eligibility Information

A. Effective Date of this Policy shall be ______. The effective date of this change to the policy shall be **1/1/2003**. This Policy may be terminated by the applicant or BCBSF/HOI by giving at least 45 days prior written notice to the other party except in the case of non-payment of Premium.

B. Only active eligible employees who regularly work a minimum of **20** hours each week and their eligible dependents, shall be eligible for coverage upon the Effective Date of this Policy.

C. Specify classification of enrollees for whom coverage is being requested, if other than eligible employees as described in B above.

D. New eligible employees may be covered effective on the **All(except Loc. 01)1st of the month after 90 days/ Loc.01 Date of Hire for New Employees.** after **90** days of employment, so long as the eligible employee submits an application to BCBSF/HOI within 30 days of the date the individual first meets the applicable eligibility requirements.

E. At least **75** % of the eligible employees must be enrolled under the Policy on the Effective Date and throughout the term of the Policy.

F. BCBSF/HOI shall have the right to audit the applicant's payroll records at any time to confirm eligibility for coverage; applicant agrees to furnish any such request.

G. Employer Contribution Employee **100** % Dependents **0** %

III. Health Plan Summary Information (select the appropriate box[s]):

Mandated Benefit Offerings: (Optional) Applicant has been advised of the following benefit offerings mandated by the Federal and/or State Law. Applicant's decision to accept or decline these benefits is indicated below:

Included in product	Accept	Decline		Included in product	Accept	Decline	
☒	☐	☐	Mental & Nervous Disorder	☒	☐	☐	Mammograms Waiver of Ded. & Coins.
☒	☐	☐	Alcohol & Drug Dependency	☒	☐	☐	Enteral Formulas

BlueCross and Blue Shield of Florida, Inc. ☐ Multi-plan BlueOptions Package* ☐ Other BCBSF Multi-plan selections*

Divisions: **001** ***Complete page 2 for plans selected and rates**
Health Benefits: **BlueChoice PPO PhyCopay 706 - Std** Pre-Existing **Pre-Existing Applies 6/12**

	Individual	Family		Participating	Non-Participating
Deductible/Calendar Year	300	900	Hospital Per Admission Deductible	0	300
Maximum Out of Pocket/Calendar Year	1500	4500	Coinsurance	90	70

Office Visit Copay Family Physician **15** All Other Providers **15**
Inpatient Facility Copay Option 1 ______ Option 2 ______ Option 3 ______
Rx Option: **Bluescript IV 10/25 - Std**
Generic **10** Brand **25** Non-Preferred ______ Deductible ______ Rx Cap ______ Contraceptives **All**
Rates:
Employee Only **$366.30** Employee/Spouse **$749.07** Employee/Child(ren) **$642.92** Family **$1,044.30** Other ______

Health Options Divisions: **002**
Health Benefits: **BlueCare FQ LG Grp Plan 15 - Std** Pre-Existing **Not Applicable**
Rx Option: **BlueCare Rx 10/25C - Std**
Generic **10** Brand **25** Non-Preferred ______ Rx Cap ______ Deductible ______ Contraceptives **All**
Rates:
Employee Only **$327.02** Employee/Spouse **$669.94** Employee/Child(ren) **$583.05** Family **$939.76** Other ______

IV. Rate Information

A. Premiums/Prepayment fee are payable monthly on or before the due date which will be: ______

B. **Regular Billing**- Employee applications should be submitted thirty (30) days prior to proposed Effective Date. Employee cancellations must be submitted within 30 days of the Effective Date of the Termination.

C. The Rates established for this Policy will not be changed for the first twelve (12) months following the initial Effective Date of Coverage unless there is a change in benefits or a 15% or more change in the composition of the group. However, BCBSF/HOI may change the Rates that are to be effective after this initial twelve (12) month period of coverage by providing notice to the employer of such changed Rates forty-five (45) days prior to their Effective Date.

D. Funding Arrangements BCBSF: **Discount** HMO: **Discount**

E. Rate Comments ______

V. Applicant Responsibilities

A. The applicant shall: 1) Notify each enrollee to the benefits selected by the applicant, their Effective Date, and the termination date of coverage (in this regard, applicant acts as the agent of the enrollee, and in no event shall the applicant be deemed an agent of BCBSF/HOI for this or any other purpose, nor shall BCBSF/HOI be responsible for such notification to retirees). 2) Deliver to covered enrollees identification cards and certificates of coverage furnished by BCBSF/HOI. 3) Notify BCBSF/HOI promptly of any changes in the eligibility of enrollees covered under this Agreement. 4) List any absentees at the time of initial enrollment on the appropriate BCBSF/HOI form. Applications from absentees will be accepted at BCBSF/HOI Corporate Headquarters no later than thirty (30) days from the group's Effective Date. 5) Collect enrollee contribution, if required, and remit Premium payment/prepayment fees to BCBSF/HOI as specified in this application.

B. Applicant hereby establishes an Employee Welfare Benefit Plan for the purpose of providing for its employees or their beneficiaries medical, surgical, hospital care, or benefits in the event of sickness.

C. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

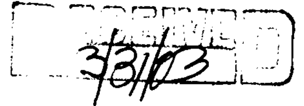
VI. Final Premiums, Benefits and Effective Dates are Subject to Approval by BCBSF Corporate Headquarters

Issuance of the Policy by BCBSF/HOI will be deemed acceptance of this application.

4-7-03	[signature]	Vickie Samus, Chairman, Bd. Co. Comm.
Date	Signature of Applicant	Print / Type Name & Title

DEPARTMENT OF HUMAN RESOURCES
2003 MAR 24 PM 4:12

NASSAU COUNTY
HUMAN RESOURCES DEPARTMENT
P. O. Box 1010
Fernandina Beach, Florida 32035-1010



MEMORANDUM

TO: Mike Mullin

FROM: HR Department

DATE: March 25, 2003

SUBJECT: Contract with Blue Cross

Attached is the contract for 2003 between Blue Cross and Nassau County that needs the Chairman's signature. Changes in this contract allow all newly hired Clerk employees (only) to be covered under health benefits the first day of hire.

NASSAU COUNTY
BOARD OF COUNTY COMMISSIONERS
P. O. Box 1010
Fernandina Beach, Florida 32035-1010

Nick Deonas — Dist. No. 1 Fernandina Beach
David C. Howard — Dist. No. 2 Fernandina Beach
Vickie Samus — Dist. No. 3 Yulee
Floyd L. Vanzant — Dist. No. 4 Hilliard
Marianne Marshall — Dist. No. 5 Callahan

JOSEPH M. "Chip" OXLEY, JR.
Ex-Officio Clerk

MICHAEL S. MULLIN
County Attorney

WALTER D. GOSSETT
County Coordinator

January 9, 2002

Mr. Ned Tyson
The Edwards Building
1553 Gerbing Road
Fernandina Beach, FL 32034

Dear Ned:

Pursuant to our conversation during open enrollment regarding the Clerk of the Court's unique hiring requirements, please ask Blue Cross to amend our contract, effective January 1, 2002, to reflect a zero-day waiting period for new employees in this constitutional office.

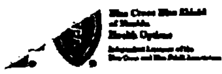
Sincerely yours,

MICHAEL S. MULLIN

MSM/am

Cc: J. M. "Chip" Oxley, Jr.
John Drew
Chili Pope

f7/Tyson-jan-09-2002



EMPLOYER APPLICATION

(True Group App.)

☐ New Business ☐ Renewal Business Other: Group Change - Eligibility Change for Location 01 (Clerk of Courts) Group # (BCBSF): 30749 (HMO) 30749J

I. APPLICANT INFORMATION

A. Name of Group: NASSAU COUNTY BOCC Div # [BCBSF]: 001
Nature of Business: Executive offices SIC Code: 9111 Div# [HMO]: 002
Mailing Address: P.O. BOX 1010 FERNANDINA BCH, FL 32035-1010
List below Subsidiary or Affiliated Companies whose employees are to be eligible and included with this application.
Name: ______ Address ______

B. Applicant hereby applies for coverage/membership through Blue Cross and Blue Shield of Florida, Inc. (BCBSF) and/or Health Options, Inc. (HOI) Group Contract (herein referred to as the Contract). Upon acceptance of this application by BCBSF and/or HOI, it will become part of the Contract issued to the applicant named above.

C. The Contract benefits do not cover any service or supply to diagnose or treat any Condition resulting from or in connection with a insured's job or employment (e.g., any service or supply which is covered by Worker's Compensation insurance). Benefits will not be provided under the Contract to an individual who elects and is statutorily authorized for exemption from Worker's Compensation coverage.

D. Worker's Compensation carrier is BITUMINOUS CASUALTY CORP.
Prior Carrier is: FLORIDA LEAGUE OF CITIES (HMO) ______

II. EFFECTIVE DATE / ELIGIBILITY INFORMATION

A. Effective Date of this Contract shall be 02/01/2002. This Contract may be terminated by the applicant or BCBSF/HOI by giving at least 45 days prior written notice to the other party.

B. Only active eligible employees who regularly work a minimum of 20 hours each week and their eligible dependents, shall be eligible for coverage upon the Effective Date of this Contract.

C. Specify classification of enrollees for whom coverage is being requested, if other than eligible employees as described in B above.

D. New eligible employees may be covered after All(except Loc. 01)1st of the month after 90 days/ Loc.01 Date of Hire of employment, so long as the eligible employee submits an application to BCBSF/HOI within 30 days of the date the individual first meets the applicable eligibility requirements.

E. At least 75 % of the eligible employees and 60 % of the eligible dependents must be enrolled under the Contract on the Effective Date and throughout the term of the Contract.

F. Enrollment data:

	Total Employees	Ineligible Employees*	Total Eligible	Number Enrolled	Percent Enrolled	Multi-Option Split PPO	Multi-Option Split HMO	
Employees	622	61	561	561	100	63	498	0

Employer Contribution: EMP: 100 % DEP: 0 % *Please provide a list of name(s) and reason(s) for ineligible employees and dependents.

G. BCBSF/HOI shall have the right to audit the applicant's payroll records at any time to confirm eligibility for coverage; applicant agrees to furnish any such records upon request.

III. HEALTH PLAN SUMMARY INFORMATION (select the appropriate box[s]):

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC. ☒ Standard ☐ Non Standard ☐ Custom

A. Health Care Benefits: BlueChoice PPO PhyCopay 706
B. Benefits: Co Ins.: 90 % PPC 70 % Non PPC

300	Deductible Per Person Per Calendar Year
900	Deductible Family Aggregate Per Calendar Year
15	Copay: Per Office Visit
300	Per Adm. Deductible For All Non-PPC Hospitals
1500	Maximum Out of Pocket

C. Rx Program: Copay: 10 Generic 25 Brand ___ NonPreferred
Bluescript IV 10/25 Contraceptives: All

MANDATED BENEFIT OFFERINGS

(Optional) Applicant has been advised of the following benefit offerings as mandated by the Federal and/or State Law. Applicant's decision to accept or decline these benefits is indicated below:

Accept	Decline	
☐	☒	Mental & Nervous Disorder
☐	☒	Alcohol & Drug Dependency
☐	☒	Mammograms Waiver of Deductible & Coinsurance
☐	☒	Enteral Formulas

HEALTH OPTIONS

☒ Standard ☐ Non-Standard ☐ Custom
A. Health Options Plan #: BlueCare FQ LG Grp Plan 15
B. Rx: BlueCare Rx 10/25C
10 Generic 25 Brand ___ NonPreferred
Contraceptive All
C. Vision ☐ Yes ☒ No

PRE-EXISTING: Pre-Existing Applies

D. Dental: ☐ Standard ☐ Non-Standard With Orthodontics ☐ Yes ☒ No DentalEnrollment: ______

E. Other: ______

IV. RATE INFORMATION

A. Premiums/Prepayment fee are payable monthly on or before the due date which will be determined:
Regular Billing - Employee applications should be submitted thirty (30) days prior to proposed effective date.

	HMO	BCBSFL	
Employee	$267.74	$299.90	
Employee / Spouse	$548.60	$613.29	
Employee / Child(ren)	$477.36	$626.38	
Employee / Family	$769.41	$855.00	
Other			

B. Funding Arrangements: Discount
HMO: Discount
Dental: ______
Comments: ______

The rates established for this Contract will not be changed for the first twelve (12) months following the initial effective date of Coverage. However, BCBSF/HOI may change the rates which are to be effective after this initial twelve (12) month period of coverage by providing notice to the employer of such changed rates forty-five (45) days prior to their effective date.

V. APPLICANT RESPONSIBILITIES

1. The applicant shall: 1) Notify each enrollee to the benefits selected by the applicant, their effective date, and the termination date of coverage (in this regard, applicant acts as the agent of the enrollee, and in no event shall the applicant be deemed an agent of BCBSF/HOI for this or any other purpose, nor shall BCBSF/HOI be responsible for such notification to retirees). 2) Deliver to covered enrollees identification cards and certificates of coverage furnished by BCBSF/HOI. 3) Notify BCBSF/HOI promptly of any changes in the eligibility of enrollees covered under this Agreement. 4) List any absentees at the time of initial enrollment on the appropriate BCBSF/HOI form. Applications from absentees will be accepted at BCBSF/HOI Corporate Headquarters no later than thirty (30) days from the group's effective Date. 5) Collect enrollee contribution, if required, and remit premium payment/prepayment fees to BCBSF/HOI as specified above in Section IV. Rates.
- Applicant hereby establishes an Employee Welfare Benefit Plan for the purpose of providing for its employees or their beneficiaries medical, surgical, hospital care, or benefits in the event of sickness.
- Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

VI. FINAL PREMIUMS, BENEFITS AND EFFECTIVE DATES ARE SUBJECT TO APPROVAL BY BCBSF CORPORATE HEADQUARTERS

Issuance of the Contract by BCBSF/HOI will be deemed acceptance of this application.

2/25/02 [signature] Nick D. Deonas, Chairman
Date Signature of Applicant Print / Type Name & Title

______ ______ ______
Date Blue Cross and Blue Shield of Florida, Inc. Licensed Agent Agent License Identification Number