CS08-29 Contract No: CN08-135
Bid No: _____

BlueCross BlueShield of Florida
Health Options.

# EMPLOYER APPLICATION
## (True Group Application)

☐ New Business ☒ Renewal Business ☐ Other

## I. Group Information

Group # (BCBSF): 30749 (HMO): 30749J

A. Name of Group: NASSAU COUNTY BOCC

Nature of Business: Executive offices SIC Code: 9111

Mailing Address: 96161 Nassau Place Yulee, FL 32097

Email Address:

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.

2008 OCT -6 PM 2:08
DEPARTMENT OF HUMAN RESOURCES

C. Prior Health Carrier: Insurance

HMO

D. The Policy excludes expenses for any service or supply to diagnose or treat any Condition 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. Workers Compensation Carrier is: BITUMINOUS CASUALTY CORP.

## II. Effective Date/Eligibility Information

A. Effective Date of this Policy shall be 01/01/2000

Effective Date of this Change to the Policy shall be 10/01/2008

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 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. *Please See Attached

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 See Special Instructions ** 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. **See attached e-mail.

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 and the Group must meet and continue to meet BCBSF/HOI's participation requirements.

F. BCBSF/HOI shall have the right to audit the applicant's payroll records at any time to confirm eligibility for coverage, including participation percentage criteria required by BCBSF/HOI. Applicant agrees to furnish any such request.

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

*Please see attached.

BlueCross BlueShield of Florida
Health Options.

# EMPLOYER APPLICATION
## (True Group Application)

### 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 | |
|---|---|---|---|
| ☒ | ☐ | ☐ | Mental & Nervous Disorder |
| ☒ | ☐ | ☐ | Alcohol & Drug Dependency |
| ☒ | ☐ | ☐ | Mammograms Waiver of Deductible & Coinsurance |
| ☒ | ☐ | ☐ | Enteral Formulas |

☐ Single Plan ☒ Blue Packages

Health Plan Name: **BlueOptions Advantage 1750 - Std**

Rx Option *(indicate copayments)*: **BlueScript C Copay Plan 15/30/50 C - Std**

Maximum Out of Pocket: $2,500/$7,500
Calendar Year Deductible:

Per Person: **$0 / $500**

Per Family: **$0 / $1,500**

Pre-Existing: **Pre-Existing Applies**

Coinsurance:

In-Network / Participating: **90**

Out-of-Network / Non-Participating: **50**

Office Visit Copay:

Family Phy.: **$15**

All Other Providers: **$30**

**Rates.**

Employee **$438.55** Employee/Spouse **$907.80** Employee/Child(ren) **$824.46** Family **$1,392.39** Other

Health Plan Name: **BlueOptions SN Hlth Pl 1160 - Std**

Rx Option *(indicate copayments)*: **BlueScript G - In-Network CYD + $10/25/40**

In-Network Maximum Out of Pocket $5,000 - Out-ofNetwork Maximum Out of Pocket $10,000
Calendar Year Deductible:

Per Person: **$1,250 / $2,500**

Per Family: **N/A / N/A**

Pre-Existing: **Pre-Existing Applies**

Coinsurance:

In-Network / Participating: **80**

Out-of-Network / Non-Participating: **60**

Office Visit Copay:

Family Phy.: **CYD + 80%**

All Other Providers: **CYD + 80%**

**Rates.**

Employee **$259.94** Employee/Spouse **N/A** Employee/Child(ren) **N/A** Family **N/A** Other **N/A**

BlueCross BlueShield of Florida
Health Options.

# EMPLOYER APPLICATION
## (True Group Application)

| Health Plan Name | Rx Option *(indicate copayments)* |
|---|---|
| **BlueOptions FM Hlth Pl 1161 - Std** | **BlueScript G - In-Network CYD +$10/25/40** |

In-Network Maximum Out of Pocket $5,000/$5,000 - Out-of-Network Maximum $10,000/$10,000

Calendar Year Deductible:

| | |
|---|---|
| Per Person | **$2,500 / $5,000** |
| Per Family | **$2,500 / $5,000** |
| Pre-Existing | **Pre-Existing Applies** |

Coinsurance:

| | |
|---|---|
| In-Network / Participating | **80** |
| Out-of-Network / Non-Participating | **60** |

Office Visit Copay:

| | |
|---|---|
| Family Phy. | **CYD + 80%** |
| All Other Providers | **CYD + 80%** |

**Rates.**

Employee **N/A** Employee/Spouse **$538.08** Employee/Child(ren) **$488.68** Family **$825.31** Other **N/A**

| Health Plan Name | Rx Option *(indicate copayments)* |
|---|---|
| **BlueCare NFQ LG Grp Plan 16 - Std** | **BlueCare Rx 15/30/50 C - Std** |

Maximum Out of Pocket: $1,500/$3,000

Calendar Year Deductible:

| | |
|---|---|
| Per Person | |
| Per Family | |
| Pre-Existing | **Pre-Existing Applies** |

Coinsurance:

| | |
|---|---|
| In-Network / Participating | |
| Out-of-Network / Non-Participating | |

Office Visit Copay:

| | |
|---|---|
| Family Phy. | **$15** |
| All Other Providers | **$45** |

**Rates.**

Employee **$494.38** Employee/Spouse **$1,012.80** Employee/Child(ren) **$881.42** Family **$1,420.69** Other

See the Group Master Policy for a complete description of benefits.

## IV. Health Saving Account (HSA) Banking Arrangement (optional with HSA Compatible health plans)

A. Are you choosing BCBSF's integrated HSA banking arrangement? (if left blank, the response is assumed to be No.) ☐ Yes ☒ No

## V. Rate Information

A. Premium/Prepayment fee are payable monthly on or before the due date which will be: **1st**

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:

BlueCross BlueShield of Florida
Health Options.

# EMPLOYER APPLICATION
# (True Group Application)

## VI. 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. By choosing the HSA Banking Arrangement, if applicable, I authorize BCBSF to exchange certain limited information, for employees enrolling in a high deductible health plan designed for use with an HSA, **with BCBSF's preferred bank**, for the purposes of initial enrollment in and administration of, HSAs. I recognize that BCBSF does not provide banking services and that BCBSF is not responsible for the provision of HSA services. HSA services are provided by the bank of your choice subject to the terms and conditions of such arrangements, including fees the bank may charge.

C. 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.

D. 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.

## VII. 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.

| Date | Signature of Applicant | Print/Type Name & Title |
|---|---|---|
| 9-10-08 | Marianne Marshall | Marianne Marshall, Chair |

| Date | Blue Cross and Blue Shield of Florida, Inc. and/or Health Options, Inc. Licensed Agent (Print) |
|---|---|
| | |

| Signature of Agent | Agent License Identification Number |
|---|---|
| | |

EMPLOYEE CONTRIBUTION: Employees hired on or after October 1, 2005 will be responsible for 100% of the dependents coverage. The county will only pay for 100% of the employees Blue Options Plan 1750 & 1160(1) Coverage, employees are responsible to buy-up to the HMO plan 16. All employees hired prior to October 1, 2005 will be grandfathered into the current 100% / 50% for Blue Options Plan 1750 & 1160(1), and will be responsible to buy-up the difference for the HMO plan 16. The employee contribution for Union Workers will be specific to their union contract.

LOCATION CODES ARE AS FOLLOWS:
00 - BOARD OF COUNTY COMMISSIONERS
01 - CLERK OF COURT'S OFFICE
02 - PROPERTY APPRAISER 'S OFFICE
03 - SUPERVISOR OF ELECTION'S OFFICE
04 - TAX COLLECTOR'S OFFICE
05 - SHERIFF'S OFFICE
06 - RETIREES

ELIGIBLE EMPLOYEES:
00 – Employees are required to work a minimum of 32 hours a week.
01 – Employees are required to work a minimum of 21 hours a week.
02 – Employees are required to work a minimum of 21 hours a week.
03 – Employees are required to work a minimum of 32 hours a week.
04 – Employees are required to work a minimum of 32 hours a week.
05 – Employees are required to work a minimum of 40 hours a week.

Marraine Marshall — 9-10-08
Signature of Applicant — date

Tom Kelly —
Signature of BCBS Sales Rep — date

BLUE CROSS/BLUE SHIELD CONTRACT
EMPLOYEE HEALTH INSURANCE

ATTEST:

9/17/08

John A. Crawford
EX-OFFICIO CLERK

EOC 9/18/08

APPROVED AS TO FORM BY THE
NASSAU COUNTY ATTORNEY

DAVID A. HALLMAN, ESQ.

BlueCross BlueShield of Florida
Health Options.

# EMPLOYER APPLICATION
# (True Group Application)

☐ New Business ☒ Renewal Business ☐ Other

## I. Group Information

Group # (BCBSF): 30749 (HMO): 30749J

A. Name of Group: NASSAU COUNTY BOCC

Nature of Business: Executive offices SIC Code: 9111

Mailing Address: 96161 Nassau Place Yulee, FL 32097

Email Address:

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

HMO

D. The Policy excludes expenses for any service or supply to diagnose or treat any Condition 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. Workers Compensation Carrier is: BITUMINOUS CASUALTY CORP.

## II. Effective Date/Eligibility Information

A. Effective Date of this Policy shall be 01/01/2000

Effective Date of this Change to the Policy shall be 10/01/2007

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 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 See Special Instructions ** 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. **See attached e-mail.

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 and the Group must meet and continue to meet BCBSF/HOI's participation requirements.

F. BCBSF/HOI shall have the right to audit the applicant's payroll records at any time to confirm eligibility for coverage, including participation percentage criteria required by BCBSF/HOI. Applicant agrees to furnish any such request.

G. Employer Contribution: Employee: 100 % Dependents: 0 % *Please see attached.

BlueCross BlueShield of Florida
Health Options.

# EMPLOYER APPLICATION
# (True Group Application)

## 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 | |
|---|---|---|---|
| ☒ | ☐ | ☐ | Mental & Nervous Disorder |
| ☒ | ☐ | ☐ | Alcohol & Drug Dependency |
| ☒ | ☐ | ☐ | Mammograms Waiver of Deductible & Coinsurance |
| ☒ | ☐ | ☐ | Enteral Formulas |

☐ Single Plan ☒ Blue Packages

Health Plan Name: **BlueChoice PPO PhyCopay 730 - Std**

Rx Option *(indicate copayments)*: **Bluescript V 10/25/40 - Std**

Maximum Out of Pocket (Coinsurance Only): $2,500/$7,500

Calendar Year Deductible:

Per Person: **$750**

Per Family: **$2,250**

Pre-Existing: **Pre-Existing Applies**

Coinsurance:

In-Network / Participating: **80%**

Out-of-Network / Non-Participating: **70%**

Office Visit Copay:

Family Phy.: **$15**

All Other Providers: **$25**

**Rates.**

Employee **$537.56** Employee/Spouse **$1,099.29** Employee/Child(ren) **$943.52** Family **$1,532.55** Other

Health Plan Name: **BlueOptions Advantage 1750 - Std**

Rx Option *(indicate copayments)*: **BlueScript C Copay Plan 10/25/40 C - Std**

Maximum Out of Pocket: $2,500/$7,500

Calendar Year Deductible:

Per Person: **$0 / $500**

Per Family: **$0 / $1,500**

Pre-Existing: **Pre-Existing Applies**

Coinsurance:

In-Network / Participating: **90**

Out-of-Network / Non-Participating: **50**

Office Visit Copay:

Family Phy.: **$15**

All Other Providers: **$30**

**Rates.**

Employee **$445.23** Employee/Spouse **$921.62** Employee/Child(ren) **$837.02** Family **$1,413.59** Other

BlueCross BlueShield of Florida
Health Options.

# EMPLOYER APPLICATION
# (True Group Application)

Health Plan Name: **BlueOptions SN Hlth Pl 1160 - Std**
Rx Option *(indicate copayments)*: **BlueScript G - In-Network CYD + $10/25/40 NStd**

In-Network Maximum Out of Pocket $5,000 - Out-of-Network Maximum Out of Pocket $10,000

Calendar Year Deductible:
- Per Person: **$1,250 / $2,500**
- Per Family: **N/A / N/A**
- Pre-Existing: **Pre-Existing Applies**

Coinsurance:
- In-Network / Participating: **80**
- Out-of-Network / Non-Participating: **60**

Office Visit Copay:
- Family Phy.: **CYD + 80%**
- All Other Providers: **CYD + 80%**

**Rates.**
Employee **$259.94** | Employee/Spouse **N/A** | Employee/Child(ren) **N/A** | Family **N/A** | Other **N/A**

Health Plan Name: **BlueOptions FM Hlth Pl 1161 - Std**
Rx Option *(indicate copayments)*: **BlueScript G - In-Network CYD + $10/25/40 NStd**

In-Network Maximum Out of Pocket $5,000/$5,000 - Out-of-Network Maximum $10,000/$10,000

Calendar Year Deductible:
- Per Person: **$2,500 / $5,000**
- Per Family: **$2,500 / $5,000**
- Pre-Existing: **Pre-Existing Applies**

Coinsurance:
- In-Network / Participating: **80**
- Out-of-Network / Non-Participating: **60**

Office Visit Copay:
- Family Phy.: **CYD + 80%**
- All Other Providers: **CYD + 80%**

**Rates.**
Employee **N/A** | Employee/Spouse **$538.08** | Employee/Child(ren) **$488.68** | Family **$825.31** | Other **N/A**

Health Plan Name: **BlueCare NFQ LG Grp Plan 16 - Std**
Rx Option *(indicate copayments)*: **BlueCare Rx 10/25/40 C - Std**

Maximum Out of Pocket: $1,500/$3,000

Calendar Year Deductible:
- Per Person:
- Per Family:
- Pre-Existing: **Pre-Existing Applies**

Coinsurance:
- In-Network / Participating:
- Out-of-Network / Non-Participating:

Office Visit Copay:
- Family Phy.: **$15**
- All Other Providers: **$45**

**Rates.**
Employee **$501.91** | Employee/Spouse **$1,028.22** | Employee/Child(ren) **$894.84** | Family **$1,442.32** | Other

See the Group Master Policy for a complete description of benefits.

## IV. Health Saving Account (HSA) Banking Arrangement (optional with HSA Compatible health plans)

A. Are you choosing BCBSF's integrated HSA banking arrangement? (if left blank, the response is assumed to be No.) ☐ Yes ☒ No

## V. Rate Information

BlueCross BlueShield of Florida
Health Options.

# EMPLOYER APPLICATION
# (True Group Application)

A. Premium/Prepayment fee are payable monthly on or before the due date which will be: 1st

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:

BlueCross BlueShield of Florida
Health Options.

# EMPLOYER APPLICATION
# (True Group Application)

## VI. 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. By choosing the HSA Banking Arrangement, if applicable, I authorize BCBSF to exchange certain limited information, for employees enrolling in a high deductible health plan designed for use with an HSA, **with BCBSF's preferred bank**, for the purposes of initial enrollment in and administration of, HSAs. I recognize that BCBSF does not provide banking services and that BCBSF is not responsible for the provision of HSA services. HSA services are provided by the bank of your choice subject to the terms and conditions of such arrangements, including fees the bank may charge.

C. 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.

D. 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.

## VII. 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.

| Date | Signature of Applicant | Print/Type Name & Title |
|---|---|---|
| 9/24/07 | | Jim B. Higginbotham, Chairman Nassau County Board of Commissioners |

| Date | Blue Cross and Blue Shield of Florida, Inc. and/or Health Options, Inc. Licensed Agent (Print) |
|---|---|
| | |

| Signature of Agent | Agent License Identification Number |
|---|---|
| | |

Nassau County signatures continue on the next page.

BLUE CROSS/BLUE SHIELD CONTRACT
EMPLOYEE HEALTH INSURANCE

ATTEST:

John A. Crawford
EX-OFFICIO CLERK

REVIEWED BY GENE KNAGA
DEPUTY COMPTROLLER
DATE

APPROVED AS TO FORM BY THE
NASSAU COUNTY ATTORNEY

DAVID A. HALLMAN, ESQ.

EMPLOYEE CONTRIBUTION: Employees hired on or after October 1, 2005 will be responsible for 100% of the dependents coverage. The county will only pay for 100% of the employees HMO Coverage, employees are responsible to buy-up to the PPO plan. All current employees will be grand fathered into the current 100%/50% for HMO, and will be responsible to buy-up the difference for the PPO. The employee contribution for Union Workers will be specific to their union contract.

LOCATION CODES ARE AS FOLLOWS:
00 - BOARD OF COUNTY COMMISSIONERS
01 - CLERK OF COURT'S OFFICE
02 - PROPERTY APPRAISER 'S OFFICE
03 - SUPERVISOR OF ELECTION'S OFFICE
04- TAX COLLECTOR'S OFFICE
05 - SHERIFF'S OFFICE
06 - RETIREES

Signature of Applicant — 9-24-07 date

Signature of BCBS Sales Rep — date

BlueCross BlueShield of Florida Health Options.

# ENROLLMENT SUMMARY

**COBRA COMPLIANCE (CHECK APPROPRIATE BOX)**

☑ Our company employed 20 or more full and/or part-time employees* during the previous calendar year and is subject to federal COBRA. All full and part-time common law employees of an employer are considered in determining COBRA compliance. All full time employees are counted as one employee and each part-time employee is counted as a fraction of an employee.

☐ Our company employed fewer than 20 full and/or part-time employees* during the previous calendar year and is subject to the Florida Health Insurance Coverage Continuation Act ("FHICCA"). All full and part-time common law employees of an employer are considered in determining COBRA compliance. All full time employees are counted as one employee and each part-time employee is counted as a fraction of an employee.

* For COBRA and FHICCA purposes, self-employed individuals, independent contractors and non-employee directors are not counted.

**MEDICARE SECONDARY PAYER COMPLIANCE (CHECK APPROPRIATE BOX)**

***Multiple employer plan:*** *a plan sponsored by more than one employer.* ***Multi-employer plan:*** *a plan jointly sponsored by employers and unions.*

***If you are a single employer plan:***

☑ Yes ☐ No Our company employed 20 or more employees** each working day in 20 or more calendar weeks (does not have to be consecutive weeks) during the current or preceding calendar year.

***If you are a single employer, multiple employer or a multi-employer plan:***

☑ Yes ☐ No Our company employed 100 or more employees** on 50 percent or more of the business days during the preceding calendar year.

***If you are a multiple employer or a multi-employer plan:***

☐ Yes ☐ No All employers in our Group Health Plan (GHP) employed 20 or more employees** for 20 or more consecutive weeks in either the current or preceding calendar year.

☐ Yes ☐ No At least one of the employers in our GHP employed 20 or more employees** for 20 or more consecutive weeks in either the current or preceding calendar year.

☐ Yes ☐ No All employers in our GHP employed fewer than 20 employees** for 20 or more consecutive weeks in either the current or preceding calendar year.

**** "Employees" includes all full and/or part time employe**

| I. General Information | |
|---|---|
| 1. Group Name **NASSAU COUNTY BOCC** | 2. Group Number **30749** |
| 3. Group Sales Rep/Agent **Jimmy Kelly** | 4. Effective Date **10/1/2007** |
| 5. Employer Contribution Toward Employees Premium (must be at least 50% for 1-50, 75% for 51+) | **100%** |

| II. Recap of Employee Participation | | | | |
|---|---|---|---|---|
| 1. TOTAL EMPLOYEES ON PAYROLL | | | => | 712 |
| 2. TOTAL COBRA CONTINUANTS | | | => | 2 |
| 3. TOTAL INELIGIBLE EMPLOYEES | | | Total of A+B+C => | 27 |
| **A.** Total Part Time Employee(s) | => | 17 | | |
| **B.** Total New Employee(s) (in Waiting Period) | => | 6 | | |
| **C.** Total Employee(s) Other | => | 4 | | |
| 4. TOTAL ELIGIBLE EMPLOYEES (DETERMINES GROUP SIZE & PRODUCT) | | | 1+2 Minus 3 => | 687 |
| **D.** Total Employees with Other Coverage | => | 35 | | |
| 5. TOTAL ELIGIBLE FOR PARTICIPATION | | | 4 Minus D => | 652 |
| **E.** Total Refusals | => | 35 | | |
| 6. TOTAL ENROLLED | | | 5 Minus E => | 617 |
| 7. EMPLOYEE PARTICIPATION (75% IS REQUIRED) | | | 6 Divided by 5 => | 94.6% |

**Employers must have an application completed for all employees, even those who are not taking the health coverage, and submit those applications to Blue Cross and Blue Shield of Florida, Inc. and/or Health Options, Inc. It is recommended that the employer also retain a copy of all applications.**

I certify that the above information is correct to the best of my knowledge. I understand that this information will be used to determine my company's compliance with Blue Cross and Blue Shield of Florida, Inc. and/or Health Options, Inc. eligibility and Underwriting Guidelines, as well as the applicability of State and Federal laws relating to my company and plan. Blue Cross and Blue Shield of Florida, Inc. and/or Health Options, Inc. reserves the right to request a UCT-6 or other documentation as evidence of business activity at any time and from time to time in order to validate my compliance with eligibility and Underwriting Guidelines, as well as validate the applicability of State and Federal laws.

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.

Group Officer's Signature

Human Resources Director
Title

10/11/07
Date

Human Resources Coordinator

## Tina Keiter

**From:** Olsen, Vickie [Vickie.Olsen@bcbsfl.com]
**Sent:** Thursday, September 06, 2007 9:28 AM
**To:** Tina Keiter
**Subject:** Contract Clarification

Hi Tina,

The contract states, See Special Instructions, in Section D of Item II. The special instructions listed for your group's eligibility waiting period states: 1st of the month following 90 CALENDAR days. BCBSF utilizes a 30 day month, however, since your group counts actual days, we altered the waiting period instructions.

Please advise if you are in need of further information.

Thanks,

Vickie Olsen
Account Management Specialist
5011 Gate Parkway S
Bldg 100, Suite 300
Jacksonville, FL 32256
Phone: 904-564-5907
Fax: 904-565-6221
E-mail: vickie.olsen@bcbsfl.com
*d Blue Cross Blue Shield of Florida
Please visit us at: www.bcbsfl.com
If you are an agent and need assistance with an issue, please call the Agent Service Center at 1-800-267-3156. Thanks!

gave to Tina Kieter on 10/8/07 for her to send back for original Signatures BKH

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



10/19/07 emailed Tina regarding Status. BKH



September 27, 2007

Ms. Vickie Olsen
Account Manager Specialist
Blue Cross/Blue Shield of Florida, Inc.
5011 Gate Parkway South
Building 100, Suite 300
Jacksonville, FL 32255

RE: Application for Group Health Coverage

Dear Ms. Olsen:

During a regular session of the Nassau County Board of County Commissioners held September 27, 2007, the Board approved and authorized the Chairman to sign the referenced agreement. I have enclosed two original documents for processing. Once signed, please return one fully executed agreement to my office. I have enclosed a self-addressed envelope for your convenience.

Thank you for your assistance to this matter.

If I can be of any service to you please do not hesitate to let me know.

Sincerely,

John A. Crawford
Ex-Officio Clerk

Enclosures