CS-13-213

Florida Blue

An Independent Licensee of the Blue Cross and Blue Shield Association

EMPLOYER APPLICATION (True Group Application)

☐ New Business ☒ Renewal Business ☐ Other

I. Group Information

Group # (Florida Blue): 30749 (Florida Blue HMO): 30749

A. Name of Group: NASSAU COUNTY BOCC

Nature of Business: EXECUTIVE OFFICES SIC Code: 9111

Mailing Address: 96135 NASSAU PL STE 5 YULEE,FL 32097-8635.

Email Address: cpope@nassaucountyfl.com

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 a Policy) by Blue Cross and Blue Shield of Florida, Inc., D/B/A Florida Blue and/or Health Options, Inc., D/B/A Florida Blue HMO. Upon acceptance of this application by Florida Blue and/or Florida Blue HMO, it will become part of the Policy issued to the applicant named above.

C. Prior Insurance Carrier: Insurance NO CARRIER

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: FLORIDA MUNICIPAL INSURANCE TRUST

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 10/01/2014

This Policy may be terminated by the applicant or Florida Blue/Florida Blue HMO 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 30 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.

Eligibility - Dependent Eligibility Endorsement - Dependent Age 26 (end of CY)

D. New eligible employees may be covered effective on the 1st of the month after 60 days of employment, so long as the eligible employee submits an application to Florida Blue/Florida Blue HMO within 30 days of the date the individual first meets the applicable eligibility requirements.

E. At least 65 % 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 Florida Blue/Florida Blue HMO participation requirements.

F. Florida Blue/Florida Blue HMO 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 Florida Blue/Florida Blue HMO.

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

EMPLOYER APPLICATION
(True Group Application)

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	
☒	☐	☐	Mental & Nervous Disorder
☒	☐	☐	Alcohol and drug dependency
☒	☐	☐	Mammograms Waiver of Deductible & Coinsurance
☒	☐	☐	Enteral Formulas

☒ Single Plan ☐ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
BlueOptions Network Advantage Plans 03769 - NSTD	**BlueScript Rx OOP Int $10/$30/$50C - STD**

Benefit Period : 01/01/2014 - 12/31/2014

Deductible :

Per Person	$500 / $1,500
Per Family	$1,500 / $4,500
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	50% / 50%

Office Visit Copay:

Family Physician	$25
All Other Providers	$60

Rates

Employee	$670.91	Employee/Spouse	$1389.50	Employee/Child(ren)	$1261.95	Family	$2131.25
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	N/A

Florida Blue

An Independent Licensee of the Blue Cross and Blue Shield Association

EMPLOYER APPLICATION
(True Group Application)

☒ Single Plan ☐ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
HSA Compatible Plans 05192 - NSTD	BlueScript G In-network DED + $10/$50/$80C - STD

Benefit Period : 01/01/2014 - 12/31/2014

Deductible :

Per Person	$2,500 / $5,000
Per Family	Not Applicable / Not Applicable
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	60% / 40%

Office Visit Copay:

Family Physician	DED + 20%
All Other Providers	DED + 20%

Rates

Employee	$429.76	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	N/A
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	N/A

☒ Single Plan ☐ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
HSA Compatible Plans 05193 - NSTD	BlueScript G In-network DED + $10/$50/$80C - STD

Benefit Period : 01/01/2014 - 12/31/2014

Deductible :

Per Person	$5,000 / $10,000
Per Family	$5,000 / $10,000
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	60% / 40%

Office Visit Copay:

Family Physician	DED + 20%
All Other Providers	DED + 20%

Rates

Employee	N/A	Employee/Spouse	$889.58	Employee/Child(ren)	$807.94	Family	$1364.47
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	N/A

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

EMPLOYER APPLICATION
(True Group Application)

☒ Single Plan ☐ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
BlueCare NFQ LG GRP Plan 45 - NSTD	BlueCare Rx OOP INT $10/$50/$80C - STD

Benefit Period : 01/01/2014 - 12/31/2014

Deductible :

Per Person	$1,500 / Not Applicable
Per Family	$4,500 / Not Applicable
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	90% / 10%
Out-of-Network/Non-Participating	Not Applicable / Not Applicable

Office Visit Copay:

Family Physician	$30
All Other Providers	$55

Rates

Employee	$547.92	Employee/Spouse	$1134.20	Employee/Child(ren)	$1030.08	Family	$1739.64
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	N/A

☒ Single Plan ☐ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
BlueCare NFQ LG GRP Plan 60 - NSTD	BlueCare Rx OOP INT $10/$30/$50C - STD

Benefit Period : 01/01/2014 - 12/31/2014

Deductible :

Per Person	$500 / Not Applicable
Per Family	$1,000 / Not Applicable
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	90% / 10%
Out-of-Network/Non-Participating	Not Applicable / Not Applicable

Office Visit Copay:

Family Physician	$25
All Other Providers	$45

Rates

Employee	$614.96	Employee/Spouse	$1272.98	Employee/Child(ren)	$1156.13	Family	$1952.50
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	N/A

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

IV. Health Savings Account (HSA), Health Reimbursement Arrangement (HRA) or Flexible Spending Account (FSA)

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

B. If Yes is selected above, which type of accounts are you choosing ☐ HSA ☐ HRA ☐ FSA
NOTE: Applicant must have elected an HSA compatible plan to be able to offer an HSA with preferred administrator.

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.

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

EMPLOYER APPLICATION
(True Group Application)

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:	**ANNUAL REFND NO SPEC STOP LOSS**
HMO:	**ANNUAL REFND NO SPEC STOP LOSS**

E. Rate Comments:

GROUP IS UNDER PROSHARE AGREEMENT
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 employee. All current employees will be grandfathered into the current 100% / 50%.
The employee contribution for Union Workers will be specific to their union contract.

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

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. 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.

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. Applicant understands that if applying for an HSA-qualified High Deductible Health Plan and electing to grant Prior Carrier Credit under Florida law to enrolling Employees, then that plan may no longer qualify as an HSA-compatible plan.

E. If applicant chose an HSA, HRA or FSA integrated arrangement with BCBSF's preferred administrator, applicant agrees to obtain from each employee enrolling in a health plan issued or administered by BCBSF and establishing an HSA, HRA or FSA in conjunction therewith, the employee's signed HIPAA compliant authorization form that authorizes BCBSF to disclose to BCBSF's preferred administrator such information, including information, of the employee as the administrator may require in order to establish and protected health maintain the employee's HSA, HRA or FSA accounts. Applicant acknowledges and agrees that BCBSF does not provide banking or administrative services for HSA, HRA of FSAs and that BCBSF is not responsible for the provision of HSA,HRA or FSA services. HSA, HRA or FSA services are provided by the administrator of applicant's choice subject to the terms and conditions of such agreements, including any fees that the administrator may require.

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

Issuance of the Policy by Florida Blue/Florida Blue HMO will be deemed acceptance of this application.

Date	Signature of Applicant	Print/Type Name & Title
7-16-14		Barry V. Holloway, Chairman

Date	Florida Blue and/or Florida Blue HMO Licensed Agent (Print)

Signature of Agent	Agent License Identification Number

Health and vision insurance is offered by Blue Cross and Blue Shield of Florida, Inc., D/B/A Florida Blue. HMO coverage is offered by Health Options, Inc., D/B/A Florida Blue HMO, an HMO subsidiary of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

NEG 07.16.14