



# EMPLOYER APPLICATION (True Group Application)

cm-1996  
CS-13-17

New Business     Renewal Business     Other

## I. Group Information

Group # (BCBSF):  (HMO):

A. Name of Group:

Nature of Business:  SIC Code:

Mailing Address:

Email Address:

List below Subsidiary or Affiliated Companies whose employees are to be eligible and included with this application.

Name	Address
<input type="text"/>	<input type="text"/>

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:

## II. Effective Date/Eligibility Information

A. Effective Date of this Policy shall be

Effective Date of this Change to the Policy shall be

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  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  after  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  % 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:  % Dependents:  %

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### 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	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental & Nervous Disorder
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol and drug dependency
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mammograms Waiver of Deductible & Coinsurance
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enteral Formulas

Single Plan

Blue Packages

<b>Health Plan Name</b>		<b>Rx Option (indicate copayments)</b>	
HSA Compatible Plans 05192 - NSTD		BlueScript G In-network DED + \$10/\$50/\$80C - STD	
OOP Max In: \$5,800		OOP Max Out: \$11,600	
<b>Benefit Period :</b> 01/01/2013 - 12/31/2013		<b>Coinsurance:</b>	
<b>Deductible :</b>		In-Network / Participating <span style="float: right;">80% / 20%</span>	
Per Person	\$2,500 / \$5,000	Out-of-Network/Non-Participating	60% / 40%
Per Family	Not Applicable / Not Applicable	<b>Office Visit Copay:</b>	
Pre-Existing	Applies	Family Phy.	DED + Coinsurance
<b>Rates</b>		All Other Providers	DED + Coinsurance
Employee	\$429.76	Employee/Spouse	N/A
Spouse	N/A	Child(ren)	N/A
		Employee/Child(ren)	N/A
		Spouse/Child(ren)	N/A
		Family	N/A
		Other	N/A



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Single Plan

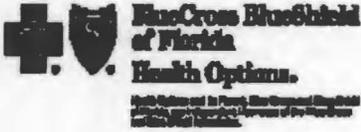
Blue Packages

Health Plan Name		Rx Option (indicate copayments)	
HSA Compatible Plans 05193 - NSTD		BlueScript G In-network DED + \$10/\$50/\$80C - STD	
OOP Max In: \$11,600		OOP Max Out: \$23,200	
Benefit Period : 01/01/2013 - 12/31/2013		Coinsurance:	
Deductible :		In-Network / Participating	80% / 20%
Per Person	\$5,000 / \$10,000	Out-of-Network/Non-Participating	60% / 40%
Per Family	\$5,000 / \$10,000	Office Visit Copay:	
Pre-Existing	Applies	Family Phy.	DED + Coinsurance
Rates		All Other Providers	DED + Coinsurance
Employee	N/A	Employee/Spouse	\$889.58
Spouse	N/A	Child(ren)	N/A
		Employee/Child(ren)	\$807.94
		Spouse/Child(ren)	N/A
		Family	\$1364.47
		Other	N/A

Single Plan

Blue Packages

Health Plan Name		Rx Option (indicate copayments)	
BlueOptions Network Advantage Plans 03769 - NSTD		BlueScript I \$10/\$30/\$50C - STD	
OOP Max In: \$3,000/\$6,000		OOP Max Out: \$6,000/\$12,000	
Benefit Period : 01/01/2013 - 12/31/2013		Coinsurance:	
Deductible :		In-Network / Participating	80% / 20%
Per Person	\$500 / \$1,500	Out-of-Network/Non-Participating	50% / 50%
Per Family	\$1,500 / \$4,500	Office Visit Copay:	
Pre-Existing	Applies	Family Phy.	\$25
Rates		All Other Providers	\$60
Employee	\$670.91	Employee/Spouse	\$1389.50
Spouse	N/A	Child(ren)	N/A
		Employee/Child(ren)	\$1261.95
		Spouse/Child(ren)	N/A
		Family	\$2131.25
		Other	N/A



# EMPLOYER APPLICATION (True Group Application)

Single Plan       Blue Packages

Health Plan Name <b>BlueCare NFQ LG Plan 042 - Cust</b>		Rx Option (indicate copayments) <b>BlueCare Rx \$10/\$30/\$50C - STD</b>	
OOP Max: \$4,000/\$8,000 - \$3,500/\$7,000			
Benefit Period : <b>01/01/2013 - 12/31/2013</b>		Coinsurance:	
Deductible :		In-Network / Participating	<b>90% / 10%</b>
Per Person	<b>\$500 / Not Applicable</b>	Out-of-Network/Non-Participating	<b>Not Applicable</b>
Per Family	<b>\$1,000 / Not Applicable</b>	Office Visit Copay:	
Pre-Existing	<b>Applies</b>	Family Phy.	<b>\$25</b>
Rates		All Other Providers	<b>\$45</b>
Employee	<b>\$614.96</b>	Employee/Spouse	<b>\$1272.98</b>
Spouse	<b>N/A</b>	Child(ren)	<b>N/A</b>
Employee/Child(ren)	<b>\$1156.13</b>	Family	<b>\$1952.50</b>
Spouse/Child(ren)	<b>N/A</b>	Other	<b>N/A</b>

Single Plan       Blue Packages

Health Plan Name <b>BlueCare NFQ LG GRP Plan 45 - NSTD</b>		Rx Option (indicate copayments) <b>BlueCare Rx Plan \$10/\$50/\$80C - STD</b>	
OOP Max: \$4,000/\$8,000			
Benefit Period : <b>01/01/2013 - 12/31/2013</b>		Coinsurance:	
Deductible :		In-Network / Participating	<b>90% / 10%</b>
Per Person	<b>\$1,500 / Not Applicable</b>	Out-of-Network/Non-Participating	<b>Not Applicable</b>
Per Family	<b>\$4,500 / Not Applicable</b>	Office Visit Copay:	
Pre-Existing	<b>Applies</b>	Family Phy.	<b>\$30</b>
Rates		All Other Providers	<b>\$55</b>
Employee	<b>\$547.92</b>	Employee/Spouse	<b>\$1134.20</b>
Spouse	<b>N/A</b>	Child(ren)	<b>N/A</b>
Employee/Child(ren)	<b>\$1030.08</b>	Family	<b>\$1739.64</b>
Spouse/Child(ren)	<b>N/A</b>	Other	<b>N/A</b>

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.



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- 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
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HMO: 

ANNUAL REFND NO SPEC STOP LOSS
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E. Rate Comments: 

<b>GROUP IS UNDER PROSHARE AGREEMENT</b> 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.
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### 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. 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 protected health information, of the employee as the administrator may require in order to establish and 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 or 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.
- C. 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.
- D. 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.
- E. 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

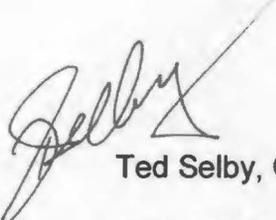
Issuance of the Policy by BCBSF/HOI will be deemed acceptance of this application.

Date	Signature of Applicant	Print/Type Name & Title
8-12-13		Daniel B. Leeper, Chairman
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**  
**Human Resources Department**  
96135 Nassau Place, Suite 5  
Yulee, Florida 32097

**MEMORANDUM**

**TO:**  Ted Selby, County Manager  
**FROM:** Tina Keiter, Human Resources Coordinator   
**DATE:** August 27, 2013  
**SUBJECT:** 2013 – 2014 Florida Blue True Group Application (TGA)

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On August 12, 2013 the above referenced document went before the BOCC as a consent item and was subsequently approved. However, after receiving the signed document back I have noticed a scrivener's error on my part. On page 4 of the document I typed in the corresponding Out of Pocket (OOP) Maximums for each plan, however inadvertently I typed in the OOP Max for Plan 45 on both Plan 45 and Plan 042.

I've attached a corrected version of this page of the document for your reference. Florida Blue is aware of this error and is willing to accept switching that page out, however we would like to know if you would like to take this back to the BOCC for informational purposes before doing so. If not, we will proceed with replacing this page in both the original documents.

Thank you.