CS-10-035

BlueCross BlueShield of Florida
Health Options.

EMPLOYER APPLICATION
(True Group Application)

☐ New Business ☒ Renewal Business ☐ Other

I. Group Information

Group # (BCBSF): 30749 (HMO):

A. Name of Group: NASSAU COUNTY BOCC

Nature of Business: EXECUTIVE OFFICES SIC Code: 9111

Mailing Address: 96135 NASSAU PL STE 5 YULEE,FL 320978635.

Email Address: NOEMAIL@.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 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 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: 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 10/01/2010

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 21 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 - LOCATION 00 - MINIMUM OF 32 HOURS LOCATION 01 - MINIMUM OF 21 HOURS LOCATION 02 - MINIMUM OF 21 HOURS LOCATION 03 - MINIMUM OF 32 HOURS LOCATION 04 - MINIMUM OF 32 HOURS LOCATION 05 - MINIMUM OF 40 HOURS

D. New eligible employees may be covered effective on the 1st of the month 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 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 %

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

☐ Single Plan ☒ Blue Packages

Health Plan Name: **BlueOptions Physician Copay Plan 03559 - STD**

OOP Max In: $2,500/$5,000

Benefit Period : 01/01/2010 - 12/31/2010

Deductible :

Per Person	$500 / $750
Per Family	$1,500 / $2250
Pre-Existing	Applies

Rates

Employee	$584.51	Employee/Spouse	$1210.56	Employee/Child(ren)	$1099.44	Family	$1856.77	Other	N/A
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A				

Rx Option *(indicate copayments)*: **BlueScript I $10/$30/$50C - STD**

OOP Max Out: $5,000/$10,000

Coinsurance:

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

Office Visit Copay:

Family Phy.	$20
All Other Providers	$40

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Health Plan Name	Rx Option *(indicate copayments)*
HSA Compatible Plans 05182 - STD	BlueScript G Intgrtd Pl In-network DED + $10/$50/$80C - STD

OOP Max In: $5,000 OOP Max Out: $10,000

Benefit Period : 01/01/2010 - 12/31/2010

Deductible :

Per Person	$2,500 / $5,000	Out-of-Network/Non-Participating	60% / 40%
Per Family	Not Applicable / Not Applicable	**Office Visit Copay:**	
Pre-Existing	Applies	Family Phy.	DED + Coinsurance
Rates		All Other Providers	DED + Coinsurance

Coinsurance:

In-Network / Participating 90% / 10%

Employee	$371.30	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	N/A	Other	N/A
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A				

☐ Single Plan ☒ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
HSA Compatible Plans 05183 - STD	BlueScript G Intgrtd Pl In-network DED + $10/$50/$80C - STD

OOP Max In: $10,000 OOP Max Out: $20,000

Benefit Period : 01/01/2010 - 12/31/2010

Deductible :

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

Coinsurance:

In-Network / Participating 90% / 10%

Employee	N/A	Employee/Spouse	$768.60	Employee/Child(ren)	$698.05	Family	$1178.88	Other	N/A
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A				

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☒ Single Plan ☐ Blue Packages

Health Plan Name		Rx Option *(indicate copayments)*	
Lower Cost Plan 05360 - STD		BlueScript I Copay Pl $10/$30/$50C - NSTD	
OOP Max In: $5,000/$10,000		OOP Max Out: $8,000/$16,000	
Benefit Period :	01/01/2010 - 12/31/2010	**Coinsurance:**	
Deductible :		In-Network / Participating	80% / 20%
Per Person	$1,500 / $3,000	Out-of-Network/Non-Participating	60% / 40%
Per Family	$4,500 / $9,000	**Office Visit Copay:**	
Pre-Existing	Applies	Family Phy.	$25
Rates		All Other Providers	$50

Employee	$473.91	Employee/Spouse	$981.01	Employee/Child(ren)	$890.96	Family	$1504.68	Other	N/A
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A				

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? ☐ Yes ☒ No

(if left blank, the response is assumed to be 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: ANNUAL REFND NO SPEC STOP LOSS

HMO: Not Applicable

E. Rate Comments:

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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. 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 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
9-13-10	Michael H. Boyle	Michael H. Boyle, 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

ATTEST AS TO CHAIRMAN'S SIGNATURE ONLY

BLUE CROSS/BLUE SHIELD CONTRACT
EMPLOYEE HEALTH INSURANCE

ATTEST:

John A. Crawford
EX-OFFICIO CLERK

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 Blue Options Plan 05360 & 05182(3) Coverage, employees are responsible to buy-up to the Blue Options plan 03559. All employees hired prior to October 1, 2005 will be grandfathered into the current 100% / 50% for Blue Options Plan 05360 & 05182(3), and will be responsible to buy-up the difference for the Blue Options plan 03559. 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

Michael H. Boyle
Signature of Applicant

9-13-10
date

Signature of BCBS Sales Rep

date

ATTEST AS TO CHAIRMAN'S SIGNATURE ONLY

9/13/10