Agenda Item # 17
Date 12/1/21

BlueCross BlueShield Nebraska

Master Group Application
BlueFreedom

Internal Use Only:

☐ New Group ☑ Renewal ☐ Sub Account/Roll Listing Attached ☐ Revision

Account No. 103968 Sub Account No. _____ ☐ Bill group on single bill ☐ Bill group at sub account level

Unique Prefix (if applicable): _____ Master Group No.: 10013 NAICS: 921110

Effective Date: This coverage shall be effective on 1/1/2022 (Effective Date) provided this Master Group Application (Application) is accepted by Blue Cross and Blue Shield of Nebraska (BCBSNE) and payment of the charges is made as provided in this Application. The renewal date will be exactly one year from the Effective Date or 1/1/2023. Changes in the terms of this Application may be made only during the anniversary month of the Effective Date, unless prior BCBSNE approval is obtained for an off-anniversary change. In the absence of the Group providing Us written documentation regarding its plan year, the Group's plan year for all purposes shall be coincident with the Group's renewal date as stated on the Group's renewal confirmation or Master Group Application.

APPLICANT INFORMATION

A. Application/Employer DODGE COUNTY

(If Employer Name is over 40 characters, please provide an abbreviated 40 character name BCBSNE system use)

Physical Address: (must be a Nebraska address)

435 NORTH PARK STREET ROOM 102
(Street)

FREMONT NE 68025
(City, State, Zip Code)

Mailing/Billing Address (if different than physical):

_____
(Street) (PO Box)

_____
(City, State, Zip Code)

Employer Tax Identification Number (EIN): 47-6006454

Group Leader/Group Health Plan Primary Contact

Name: BOB MISSEL
Title: Chairman of the Board of Supervisors
Phone: 402-317-7832
Email: clerk@dodge.nacone.org
Allow BluesEnroll Access? ☑ Yes ☐ No

Billing Contact (if different)

Name: MICKI GILFRY
Title: PAYROLL CLERK
Phone: 402-727-2767
Email: CLERK@DODGE.NACONE.ORG
Allow BluesEnroll Access? ☑ Yes ☐ No

B. Please select one contact at the group who should receive correspondence. If other is selected, please indicate below who should receive correspondence.

☐ Group Leader/Group Health Plan Primary Contact ☑ Billing Contact ☐ Other

Name: _____
Title: _____
Phone: _____
Email: _____
Allow BluesEnroll Access? ☐ Yes ☐ No

NOTE: If you have additional Authorized Plan Contacts (APC), please enter them on page 8.

C. Is your company headquartered in Nebraska? ☑ Yes ☐ No

Do you have any additional business locations? ☐ Yes ☑ No If yes, please provide names:

_____

D. Names of subsidiaries or affiliated organizations to be covered (must be majority-owned - 51% or greater).

_____

EIN(s) of subsidiaries or affiliates: _____

E. Is the Group Health Plan subject to the Employee Retirement Income Security Act of 1974 (ERISA)? ☐ Yes ☑ No

F. Is the Group Health Plan subject to the Consolidated Omnibus Reconciliation Act (COBRA), as amended, during this calendar year? ☑ Yes ☐ No

If yes, does the Group have a COBRA Administrator? ☐ Yes ☑ No

Does the group have a direct relationship with the vendor? ☐ Yes ☑ No

Please provide name of the COBRA Administrator: _____

If through BCBSNE parternership, attach completed Employer Setup Form and create Client Service Agreement through Legal.

G. Will any other group coverage be in effect while this Contract is in force? ☐ Yes ☑ No

If yes, name of carrier(s) _____

H. **Employee Data:** The following is from and agrees with your payroll and personnel records

	Total
1. Total employees/owners on the payroll (includes full-time, part-time, leased employees)	120
2. Total eligible employees/owners on the payroll on the effective date of the Contract	120
3. Eligible employees/owners not enrolling due to:	
a. Valid Waivers (employees/owners with other coverage including Medicare, Medicaid, spousal coverage)	5
b. Invalid Waivers (employees/owners not enrolling due to cost or other reasons with no valid health coverage)	0
4. Eligible employees/owners enrolling on the effective date of the Contract	115
5. Persons on COBRA or State Continuation Coverage	1

I. Prior carrier name (if applicable): _____

J. **Other Applicant Information:**

_____

_____

_____

VENDOR INFORMATION

A. **Does the Applicant have a HSA Administrator?** ☐ Yes ☑ No

If yes, please identify the vendor below:

☐ **Discovery Benefits, Inc.** ☐ **Other** _____

Does the group have a direct relationship with the vendor? ☐ Yes ☐ No

(If Discovery Benefits is selected, attach completed Employer Setup Form and create Client Service Agreement through Legal. HSA administration is provided independently by the entity identified above. BCBSNE does not provide HSA administration. The entity identified above is solely responsible.)

B. **Does the Applicant have a HRA Administrator?** ☐ Yes ☑ No

If yes, please identify the vendor below:

☐ **Discovery Benefits, Inc.** ☐ **Employee Benefits System** ☐ **First Concord Benefits Group**

☐ **Mid-American Benefits, Inc.** ☐ **Other** _____

Does the group have a direct relationship with the vendor? ☐ Yes ☐ No

(HRA administration is provided independently by the entity identified above. BCBSNE does not provide HRA administration. The entity identified above is solely responsible. If through a BCBSNE partnership (only if Discovery Benefits, Inc. is selected), attach completed Employer Setup Form and create Client Service Agreement through Legal.

C. **Does the Applicant have a FSA Administrator?** ☐ Yes ☑ No

If yes, please identify the vendor below:

☐ **Discovery Benefits, Inc.** ☐ **Payflex Systems USA, Inc.** ☐ **First Concord Benefits Group**

☐ **Other** _____

Does the group have a direct relationship with the vendor? ☐ Yes ☐ No

(FSA administration is provided independently by the entity identified above. BCBSNE does not provide FSA administration. The entity identified above is solely responsible for its services. If through BCBSNE partnership attach completed Employer Setup Form and create Client Service Agreement through Legal.)

GROUP DATA FOR CALCULATION OF MEDICAL LOSS RATIO

As part of BCBSNE's compliance with the Patient Protection and Affordable Care Act (PPACA), BCBSNE must collect information on group sizes. On average, how many employees did you employ (business days only) during the calendar year prior to the effective date of this application? This total should include full-time, part-time, and seasonal employees, but exclude independent contractors. If your company has affiliated parent or sister companies that are members of the same control group for IRS reporting purposes, all employees in all the affiliated companies should be included in your total, whether or not the affiliated companies have coverage with BCBSNE.

☐ 50 or Fewer ☑ 51 or More

GROUP DATA FOR MEDICARE SECONDARY PAYER

BCBSNE is required to collect information in order to properly pay claims for your employees who are eligible for Medicare benefits. In accordance with Medicare law, depending on the current employment status of your employee and/ or employer size, BCBSNE may be required to pay primary to Medicare for certain group health benefits, regardless of an employee's or dependent's entitlement to Medicare.

A. **Employee Information:** Do you have employees or covered dependents enrolled in your group health plan who also currently have Medicare coverage or who are turning 65 this year? ☑ Yes ☐ No

B. **Employer Information:** When responding to questions 1 and 2 below, include full-time, part-time, leased and seasonal employees, but exclude independent contractors. If your company has affiliated parent or sister companies that are members of the same control group for IRS reporting purposes, all employees in all the affiliated companies should be included in your total, whether or not the affiliated companies have coverage with BCBSNE.

1. Did your company have 20 or more full-time and/or part-time employees* on the payroll(s) for 20 or more weeks (consecutive or non-consecutive) at any time during the **current calendar year?**

   ☑ Yes ☐ No If yes, please provide the date this threshold was reached.

   _____

2. Did your company have 20 or more full-time and/or part-time employees* on the payroll(s) for 20 or more weeks (consecutive or non-consecutive) at any time during the **previous calendar year?**

   ☑ Yes ☐ No If yes, please provide the date this threshold was reached.

   _____

   ***The number of full-time and part-time employees including owners who are active with the company on your payroll(s), not the number of employees on the group health plan, determines MSP status. Companies under common ownership/ control are treated as a single employer.**

3. Did you have 100 or more employees during 50 percent of your business days during the previous calendar year?

   ☑ Yes ☐ No

UNIFORM SUMMARY OF BENEFITS & COVERAGE

In compliance with the Patient Protection and Affordable Care Act, BCBSNE will make available to the Group Leader/ Group Health Plan Primary Contact the Group's Uniform Summary of Benefits and Coverage (SBC).

The Group, on behalf of itself and any of its Subgroups, acknowledges that it has:

☑ Received a copy of the SBC for the Group Health Plan; **or**

☐ Been given information about how to the access the SBC online.

Date received: 11/23/2021

The Group, on behalf of itself and any of its Subgroups, acknowledges and agrees as follows: (1) that it will provide the SBC to all active and eligible employees and their dependents who reside at another address (collectively "Employee"); (2) agrees to provide the SBC for all plan options available to the Employee; (3) agrees to provide the SBC in compliance with any instructions provided by BCBSNE; and (4) agrees to provide information to BCBSNE upon request to show compliance with this obligation.

The Group agrees to indemnify and hold BCBSNE harmless against any and all loss, damage, expenses, and penalties imposed by law with respect to the Group's failure to provide Employees with the SBC as agreed to herein.

Other Provisions: _____

_____

ELIGIBILITY AND ENROLLMENT

A. An employee must work a minimum of 30 hours per week on a regular calendar year basis to be eligible for coverage. Coverage for an eligible employee must become effective on:

☒ The first of the month after such employee has completed a waiting period of 30 days (not to exceed 60 days) after the date of hire.

☐ Other: _____

The employee must complete the applicable enrollment form. To remain eligible, the employee must continue to work the minimum number of hours per week required.

Other eligibility provisions: 3 TIER ELIGIBILITY = EE, EE+1 AND FAMILY

_____

If an otherwise eligible employee is not actively at work on the effective date **for other than personal health reasons,** coverage for that employee will go into effect on the group's next due date following his/her return to active employment, subject to our receipt of an enrollment form within 31 days of the return to work date. As of the effective date indicated above, there are 0 such employees not actively at work. (Attach list of names and corresponding social security numbers.)

For groups with Multiple Option structure, employees may submit Benefit Option changes during the month prior to the annual renewal date, with coverage effective on the annual renewal date, unless otherwise required per the special enrollment rules of the Health Insurance Portability and Accountability Act (HIPAA).

B. Retirees eligible? ☐ Yes ☑ No (Attach a list of retirees and copy of Retirement Program describing your eligibility requirements and your contribution toward the monthly charges.) Early retirees are not eligible for coverage. Retiree participation is subject to the requirements outlined in our Underwriting Guidelines.

C. **Late/Open Enrollment:** The open enrollment period for late enrollees is the month prior to the annual renewal date. Coverage for Late Enrollees will be effective on the annual renewal date. Enrollment Forms must be signed by the last day of open enrollment and must be received by BCBSNE within 30 days.

PLAN DESIGN

Choose your Health Benefit Plan Design, Prescription Drug Plan Design, Dental Plan Design and Medicare Supplemental Coverage by marking the applicable box below. Please indicate the applicable Network Option for the Health Plan. You must also attach the appropriate Schedule of Benefits Summary(ies). **Only choose section A OR section A-1.**

A. **Health Benefit Plan Design:** ☒ Contract 96-067

Health Option #15 Rx Option # 1

Health Option #49 Rx Option # _____ if applicable

Health Option # _____ Rx Option # _____ if applicable

☑ Prescription Drug Plan Subject to Medical Deductible and Coinsurance (eligible for QHDHP only)

Network Option(s):
Please list all network options that apply.

☑ NEtworkBLUE ☐ Premier Select BlueChoice ☐ Blueprint Health

A-1. **Health Benefit Plan Design:** ☐ EPO Contract: 96-096*

☐ EPO Option 18 ☐ EPO Option 31 ☐ EPO Option 41 ☐ EPO Option 55 ☐ EPO Option 58

NOTE: EPO Copay Plans are paired with RX Option 1.
HSA eligible EPO plans RX plans are subject to Medical Deductible and Coinsurance.
***Out-of-network benefits are not covered unless required by law or prior approved by BCBSNE.**

B. **Dental Coverage Requested:** ☐ Yes ☑ No

Dental Option: _____

C. **Group Medicare Supplement Coverage:** ☐ Yes (if yes, complete Att-Att-E) ☑ No

MONTHLY CHARGES AND EMPLOYER CONTRIBUTION

A. Does your plan have a Section 125 plan which offers employees cash in lieu of health plan benefits? ☐ Yes ☑ No

B. It is understood that the amount shown as employer contribution will be paid by you without charge to the eligible employees and the remainder collected by you from the eligible employees by payroll deduction and remitted monthly to BCBSNE.

C. The monthly charges for this coverage will not increase prior to one year from the Effective Date or from such other date written above. This rate guarantee is subject to the Applicant continuing to meet our underwriting guidelines. If the number of covered employees increases or decreases 5% or more, we reserve the right to recalculate the rates previously proposed. Off cycle rate changes may also occur due to changes in the ages of the individuals covered under the plan.

NOTE: Rates may be indicated on the attached quote.

COMPLETE CONTRIBUTION INFORMATION ON THE FOLLOWING PAGE

☐ Please check this box if you are only contributing towards the cost of the employee only (single) rate for all tiers of coverage.

☐ **For Health Coverage Only**: Please check this box if the employer contribution is different among employees within the same option. (For example, employer pays 85 percent of premium for employees earning less than $35,000; the employer pays 80 percent for those making $35,000 to $99,999; and the employer pays 75 percent for those earning more than $100,000.) If you checked this box, please describe the different employer contribution scenarios:

_____

_____

_____

_____

Plan Option: 15
Rx Option: 1
Network: NETWORK BLUE

	Employer Contribution			
	Percent	or	Fixed Amount	Total Monthly Charge
☐ Single	100%			840.60
☐ Employee & Spouse	80%		EE +1	1,723.23
☐ Employee & Child(ren)				
☐ Family	80%			2,437.74

Plan Option: 49
Rx Option:
Network: NETWORK BLUE

	Employer Contribution			
	Percent	or	Fixed Amount	Total Monthly Charge
☐ Single	100%			814.55
☐ Employee & Spouse	80%		EE +1	1,669.83
☐ Employee & Child(ren)				
☐ Family	80%			2,362.19

Plan Option:
Rx Option:
Network:

	Employer Contribution			
	Percent	or	Fixed Amount	Total Monthly Charge
☐ Single				
☐ Employee & Spouse				
☐ Employee & Child(ren)				
☐ Family				

Plan Option:
Rx Option:
Network:

	Employer Contribution			
	Percent	or	Fixed Amount	Total Monthly Charge
☐ Single				
☐ Employee & Spouse				
☐ Employee & Child(ren)				
☐ Family				

Plan Option: ____________

Rx Option: ____________

Network: ____________

	Employer Contribution			
	Percent	or	Fixed Amount	Total Monthly Charge
☐ Single	______		______	______
☐ Employee & Spouse	______		______	______
☐ Employee & Child(ren)	______		______	______
☐ Family	______		______	______

Plan Option: ____________

Rx Option: ____________

Network: ____________

	Employer Contribution			
	Percent	or	Fixed Amount	Total Monthly Charge
☐ Single	______		______	______
☐ Employee & Spouse	______		______	______
☐ Employee & Child(ren)	______		______	______
☐ Family	______		______	______

Plan Option: ____________

Rx Option: ____________

Network: ____________

	Employer Contribution			
	Percent	or	Fixed Amount	Total Monthly Charge
☐ Single	______		______	______
☐ Employee & Spouse	______		______	______
☐ Employee & Child(ren)	______		______	______
☐ Family	______		______	______

Plan Option: ____________

Rx Option: ____________

Network: ____________

	Employer Contribution			
	Percent	or	Fixed Amount	Total Monthly Charge
☐ Single	______		______	______
☐ Employee & Spouse	______		______	______
☐ Employee & Child(ren)	______		______	______
☐ Family	______		______	______

Plan Option: ____________

Rx Option: ____________

Network: ____________

	Employer Contribution			
	Percent	or	Fixed Amount	Total Monthly Charge
☐ Single	______		______	______
☐ Employee & Spouse	______		______	______
☐ Employee & Child(ren)	______		______	______
☐ Family	______		______	______

Dental Option: ____________

	Employer Contribution			
	Percent	or	Fixed Amount	Total Monthly Charge
☐ Single	______		______	______
☐ Employee & Spouse	______		______	______
☐ Employee & Child(ren)	______		______	______
☐ Family	______		______	______

AUTHORIZED PLAN CONTACTS

The HIPAA Privacy Rules provide that the Group Health Plan (GHP) is a separate legal entity from the Employer/Plan Sponsor. In compliance with the HIPAA Privacy Rules, it is necessary to designate Authorized Plan Contacts (APC) for the GHP.

The GHP Primary Contact is indicated on page 1 of this Master Group Application. The GHP Primary Contact serves as BCBSNE's primary contact for the GHP, and may also designate additional APC for the GHP. The GHP Primary Contact shall notify BCBSNE of any additions or deletions to the following list, by utilizing the Amendment to Application form and contacting your account management team.

If you want your GHP Agent of Record as one of your APC, please include him/her in the section below.
NOTE: APCs need to be noted in the MGA or they will be removed (regardless of data or amendments **submitted in prior years.)**

In addition, the following individuals may be given access to our GHP information received from BCBSNE in accordance to the requirements set forth within the HIPAA Privacy Rules.

NOTE: Do NOT duplicate Primary, Billing or Correspondence Contact information on Page 1.

Name: LISA DANIELS ☐ Group Contact ☒ Agent
Agency if applicable: NORTH RISK PARTNERS / OCI
Title: AGENT / GENERAL AGENCY
Phone Number:
Email:
Allow BluesEnroll Access? ☑ Yes ☐ No

Name: ☐ Group Contact ☐ Agent
Agency if applicable:
Title:
Phone Number:
Email:
Allow BluesEnroll Access? ☐ Yes ☐ No

Name: ☐ Group Contact ☐ Agent
Agency if applicable:
Title:
Phone Number:
Email:
Allow BluesEnroll Access? ☐ Yes ☐ No

Name: ☐ Group Contact ☐ Agent
Agency if applicable:
Title:
Phone Number:
Email:
Allow BluesEnroll Access? ☐ Yes ☐ No

Name: ☐ Group Contact ☐ Agent
Agency if applicable:
Title:
Phone Number:
Email:
Allow BluesEnroll Access? ☐ Yes ☐ No

If you have additional APC, Please check here ☐ and add supplemental sheet ensuring all information in the fields above is provided.

BCBSNE will not release protected health information (PHI) to fully insured groups, except as specifically agreed in writing by BCBSNE the Plan and Plan Sponsor. When there is a written agreement, all disclosure of PHI from BCBSNE shall be made to the Plan, or an Authorized Plan Contact.

APPLICANT CERTIFICATION AND SIGNATURE

I have read and understand the provisions of this Master Group Application for a Group Contract and certify that all information herein is true and accurate and agree to the provisions specified. I further agree that any Individual Enrollment Forms submitted to or accepted by BCBSNE which do not meet the provisions specified may be declared null, void, and without effect. I understand that if any of the information on this Application is in conflict with the proposal, BCBSNE reserves the right to recalculate and change the rates previously proposed, or to decline coverage (unless otherwise prohibited by state or federal law). I understand the possible effect of canceling our current group plan prior to receiving final approval from BCBSNE.

By signing this application, I represent that I am authorized to obtain coverage on behalf of the Group Health Plan. The Group/Plan Administrator, on behalf of itself and any subgroups, acknowledges and agrees that it is responsible to provide notice of benefit, coverage or plan changes to enrolled employees, including persons on continuation coverage, prior to the effective date of such change(s).

BOB MISSEL, CHAIRMAN — Printed Name of Applicant/Group

DODGE COUNTY BOARD OF SUPERVISORS — Title

11/24/21 — Date

Signature of Applicant/Group

AGENT CERTIFICATION:

I certify that I have verified the information in this Application for Group Contract with the records of the Applicant and it is true and accurate to the best of my knowledge.

Signature | Title | Date

(Typed Name) | (Typed Title) | (Typed Date)

Agency: _____

General Agency Name (if applicable): _____

ACCEPTANCE BY BLUE CROSS AND BLUE SHIELD OF NEBRASKA:

☐ This Master Group Application is accepted.

☐ This Master Group Application is accepted with the following changes: _____

Signature (BCBSNE) | Title | Date

The noted changes in this Part are acceptable.

Signature of Applicant | Date

Please sign both the original and the copy. Retain the copy and return the original to Blue Cross and Blue Shield of Nebraska.

FOR OFFICIAL USE ONLY

Contract No. Health _____ Dental _____ Med. Supp. _____

Endorsements: _____ _____ _____ _____ _____