BlueCross BlueShield Nebraska

Master Group Application
BluePride

☐ New Group ☐ Renewal ☐ Revision

Account/Group No. __________ Sub Account/Roll No. __________ ☐ Sub Account/Roll Listing Attached

Market Affiliation Code: __________ Rate Pool Code: __________ NAICS: __________

Effective Date: This coverage shall be effective on __________ (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 unless otherwise stated. Changes in the terms of this Application may be made only during the annual renewal month, unless prior BCBSNE approval is obtained for an off-year change.

APPLICANT INFORMATION

A. Application/Employer __________

____

(If Employer Name is over 35 characters, please provide an abbreviated 35-character name BCBSNE system use)

Physical Address

____
(Street)

____
(City, State, Zip Code)

Mailing Address

____
(Street) (PO Box)

____
(City, State, Zip Code)

Type of Business __________

Group Leader/Group Health Plan Primary Contact

(Name) __________
(Title) __________
(Phone) __________
(Fax) __________
(Email) __________

Billing Contact (if different)

(Name) __________
(Title) __________
(Phone) __________
(Fax) __________
(Email) __________

Employer (Tax) Identification Number (EIN) __________

Is your company headquartered in Nebraska? ☐ Yes ☐ No

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

____

____

B. Names of subsidiaries or affiliated organizations to be covered (must be majority-owned - 51% or greater). Please submit all documentation, including tax information, for all companies involved, or submit common ownership form:

____

EIN(s) of subsidiaries or affiliates: __________

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

D. 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.

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

If yes, name of carrier(s) ____________________

F. **Employee Data:** The following is from and agrees with your payroll and personnel records (see below for additional eligibility and enrollment information):

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

G. Prior carrier name (if applicable): ____________________

ELIGIBILITY AND ENROLLMENT

A. An employee must work a minimum of______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_____days (0, 30 or 60 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: ____________________

____

B. 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 30 days of the return to work date. As of the effective date indicated above, there are _______such employees not actively at work. (Attach list of names and corresponding social security numbers.)

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.

D. To be eligible for small group coverage, you must have two to 50 total employees, at least two of which must be a W-2 enrolled employee. The W-2 employee must be someone other than a business owner, partner or spouse.

PLAN DESIGN

Choose your Health Benefit Plan Design, Dental Plan Design and Medicare Supplement Option by marking the applicable box(es) below. **You must also attach the applicable Schedule of Benefits Summary(ies).**

A. **Health coverage requested:** ☐ Yes ☐ No

Health Benefit Plan Design (Contract 96-080): **Multiple Option:** ☐ Yes ☐ No

BluePride

☐ BluePride Option GPA20 ☐ BluePride Option SPB20 ☐ BluePride Option SHA20 ☐ BluePride Option BHA20

☐ BluePride Option GPB20 ☐ BluePride Option SPA20 ☐ BluePride Option SHB20

☐ BluePride Option GHA20 ☐ BluePride Option SPC20

☐ BluePride Option GHB20

☐ BluePride Option GPC20

Network Option (please select all that apply):

☐ NEtwork Blue ☐ Premier Select BlueChoice ☐ Blueprint Health

Premier Select BlueChoice: Only available to groups headquartered in the Omaha and Lincoln Areas
Blueprint: Only available to groups headquartered in the Omaha and Lincoln Areas as well as Buffalo, Hall, Phelps, Kearney and Adams counties.

Endorsement Listing -- All Health Plan Options include the following:

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

If yes, please identify the vendor below:

☐ **Discovery Benefits (03)** ☐ **Other** ______________________

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

HSA administration is provided independently by the entity identified above. BCBSNE does not provide HSA 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.)

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

If yes, please identify the vendor below:

☐ **Discovery Benefits (39)** ☐ **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 for its services. If through BCBSNE partnership attach completed Employer Setup Form and create Client Service Agreement through Legal.)

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

If yes, please identify the vendor below:

☐ **Discovery Benefits (39)** ☐ **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.)

E. **Dental Coverage Requested:** ☐ Yes ☐ No

Dental Plan Design:

☐ Option 1 ☐ Option 4 ☐ Option 5 ☐ Option 8 ☐ Option 9 ☐ Option 12

☐ Option 13 ☐ Option 15 ☐ Option 17 ☐ Option 19 ☐ Option 21

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

MONTHLY CHARGES AND EMPLOYER CONTRIBUTION

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.

HEALTH RATES - Employer Contribution:

The employer contribution amounts are subject to approval by BCBSNE Group Underwriting.

Health Option 1: ______________________

☐ ___________ % of employee only rate

☐ ___________ % of dependent rate

OR

☐ $__________ per employee per month

☐ $__________ per dependent per month

☐ Other: __________________________

____

____

Health Option 2: ______________________

☐ ___________ % of employee only rate

☐ ___________ % of dependent rate

OR

☐ $__________ per employee per month

☐ $__________ per dependent per month

☐ Other: __________________________

____

____

Health Option 3: ______________________

☐ ___________ % of employee only rate

☐ ___________ % of dependent rate

OR

☐ $__________ per employee per month

☐ $__________ per dependent per month

☐ Other: __________________________

____

____

Other Monthly Charge or Contribution Provisions: ____

____

DENTAL RATES - Employer Contribution:

The employer contribution amounts are subject to approval by BCBSNE Group Underwriting.

Dental Option 1: ______________________

☐ ___________ % of employee only rate

☐ ___________ % of dependent rate

OR

☐ $__________ per employee per month

☐ $__________ per dependent per month

☐ Other: __________________________

____

____

Dental Option 2: ______________________

☐ ___________ % of employee only rate

☐ ___________ % of dependent rate

OR

☐ $__________ per employee per month

☐ $__________ per dependent per month

☐ Other: __________________________

____

____

Dental Option 3: ______________________

☐ ___________ % of employee only rate

☐ ___________ % of dependent rate

OR

☐ $__________ per employee per month

☐ $__________ per dependent per month

☐ Other: __________________________

____

____

Other Monthly Charge or Contribution Provisions: ____

____

GROUP DATA FOR PPACA COMPLIANCE

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**, at what payroll date was the 20th week that your company first had 20 or more employees?

____________________(date must be between 5/20 and 12/31 of current year)

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**, at what payroll date was the 20th week that your company first had 20 or more employees?

____________________(date must be between 5/20 and 12/31 of previous year)

***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.**

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: ________________________

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.

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 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 Authorized Plan Contacts for the GHP. The GHP Primary Contact shall notify BCBSNE of any additions or deletions to the following list, by utilizing the Authorized Plan Contacts Form (8933).

If you want your GHP Agent of Record as one of your Authorized Plan Contacts, please include him/her in the section below.

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.

Authorized Plan Contacts:

Agent Name: ________________________ Email: ________________________

Agency Title: ________________________ Phone: ________________________

Allow BluesEnroll Access? ☐ Yes ☐ No General Agency Name (if applicable): ________________

Name: ________________________ Email: ________________________

Title: ________________________ Phone: ________________________

Allow BluesEnroll Access? ☐ Yes ☐ No

Name: ________________________ Email: ________________________

Title: ________________________ Phone: ________________________

Allow BluesEnroll Access? ☐ Yes ☐ No

Name: ________________________ Email: ________________________

Title: ________________________ Phone: ________________________

Allow BluesEnroll Access? ☐ Yes ☐ No

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).

Printed Name of Applicant ______ Title ______ Date ______

Signature of Applicant ______

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 ______

(Print Name) ______ (Print Title) ______ (Print 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 BCBSNE.

FOR OFFICIAL USE ONLY
Contract No. Health ______ Dental ______ Med. Supp. ______
Endorsements: ______ ______ ______ ______ ______

<u>IN ORDER TO CONFIRM THIS APPLICATION, YOU MUST ATTACH THE SCHEDULE OF BENEFITS SUMMARY FOR EVERY OPTION (INCLUDING BOTH HEALTH AND DENTAL OPTIONS) CHOSEN BY THE GROUP.</u>