BlueCross BlueShield Nebraska

Master Group Application

BlueFlex

For Claim Administration Services (ASA) and Stop Loss Insurance in 2021

Internal Use Only:

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

Bill group on single bill ☐

Bill group at sub account level ☐

Account No. _____ Sub Account No. _____ **Plan ID No. (ERISA Number)**** _____

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

**required field

This is an Application for an Administrative Services Agreement ("The Agreement") with Blue Cross and Blue Shield of Nebraska ("BCBSNE"), for the provision of claim administration services on behalf of the level funded Group Health Plan ("Plan") identified below. The Agreement includes attachments, including the Stop Loss Insurance Contract, a Master Group Contract and a HIPAA Business Associate Agreement. The Agreement and the attachments set forth the rights and duties of the parties. Execution of this Application constitutes acceptance of the terms of the Agreement and the attachments.

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 40 characters, please provide an abbreviated 40 character name BCBSNE system use)

Physical Address: (must be a Nebraska address)

_____
(Street)

_____
(City, State, Zip Code)

Mailing/Billing Address (if different than physical):

_____
(Street) (PO Box)

_____
(City, State, Zip Code)

Employer Tax Identification Number (EIN): _____

Group Leader/Group Health Plan Primary Contact		**Billing Contact (if different)**	
Name:		Name:	
Title:		Title:	
Phone:		Phone:	
Fax:		Fax:	
Email:		Email:	

B. Please advise if the above contact should receive all written BCBSNE correspondence. ☐ Yes ☐ No
If no, please provide the following information.

Name: _____

Title: _____

Phone: _____

Fax: _____

Email: _____

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) _____
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 including Medicare, Medicaid, spousal coverage) _____
   b. Invalid Waivers (employees/owners not enrolling due to cost or other reasons with no valid health coverage) _____
4. Eligible employees/owners enrolling on the effective date of the Contract _____
5. Persons on COBRA or State Continuation Coverage _____

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 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)

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

   ☐ Yes ☐ No

***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.

Other Provisions: _____

_____

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 (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.

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).**

A.

Health Benefit Plan Design (Contract 96-094):

Multiple Option: ☐ Yes ☐ No

☐ Option FPA21	☐ Option FPB21	☐ Option FPC21	☐ Option FPD21*
☐ Option FHA21 (QHDHP)	☐ Option FHB21 (QHDHP)	☐ Option FHC21 (QHDHP)	☐ Option FHD21 (QHDHP)

* This plan does not meet minimum value. To avoid the risk of penalty, we recommend groups offer a dual or triple option if this plan is selected.

Prescription Drug Benefits: All QHDHP will be paired with the prescription plan subject to deductible and coinsurance. The PPO plans listed above will be paired with RX Option 1, which has a 4 tier copay design.

Network Option - Please select all that apply

☐ NEtworkBLUE ☐ Premier Select BlueChoice ☐ Blueprint Health

B. **Dental Coverage Requested:** ☐ Yes (If yes, complete App-Att-D) ☐ No

Dental Option Selected _____

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: __________

Network: __________

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

Plan Option: __________

Network: __________

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

Plan Option: __________

Network: __________

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

Plan Option: __________

Network: __________

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

Plan Option: ________					**Plan Option:** ________				
Network: ________					**Network:** ________				
	Employer Contribution					Employer Contribution			
	Percent	or	Fixed Amount	Total Monthly Charge		Percent	or	Fixed Amount	Total Monthly Charge
☐ Single	________		________	________	☐ Single	________		________	________
☐ Employee & Spouse	________		________	________	☐ Employee & Spouse	________		________	________
☐ Employee & Child(ren)	________		________	________	☐ Employee & Child(ren)	________		________	________
☐ Family	________		________	________	☐ Family	________		________	________

Plan Option: ________					**Plan Option:** ________				
Network: ________					**Network:** ________				
	Employer Contribution					Employer Contribution			
	Percent	or	Fixed Amount	Total Monthly Charge		Percent	or	Fixed Amount	Total Monthly Charge
☐ Single	________		________	________	☐ Single	________		________	________
☐ Employee & Spouse	________		________	________	☐ Employee & Spouse	________		________	________
☐ Employee & Child(ren)	________		________	________	☐ Employee & Child(ren)	________		________	________
☐ Family	________		________	________	☐ Family	________		________	________

DENTAL RATES - Employer Contribution:

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

Dental Option: ________					**Dental Option:** ________				
	Employer Contribution					Employer Contribution			
	Percent	or	Fixed Amount	Total Monthly Charge		Percent	or	Fixed Amount	Total Monthly Charge
☐ Single	________		________	________	☐ Single	________		________	________
☐ Employee & Spouse	________		________	________	☐ Employee & Spouse	________		________	________
☐ Employee & Child(ren)	________		________	________	☐ Employee & Child(ren)	________		________	________
☐ Family	________		________	________	☐ Family	________		________	________

Other Monthly Charge or Contribution Provisions: ________________________________

____

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/Group _____ Title _____ 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: _____ _____ _____ _____ _____

IN ORDER TO CONFIRM THIS APPLICATION, YOU MUST ATTACH THE SCHEDULE OF BENEFITS SUMMARY(IES) FOR EVERY OPTION (INCLUDING BOTH HEALTH AND DENTAL OPTIONS) CHOSEN BY THE GROUP AS WELL AS THE FINAL QUOTE, ADMINISTRATIVE SERVICES AGREEMENT, STOP LOSS CONTRACT AND BUSINESS ASSOCIATE AGREEMENT (IF APPLICABLE).