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Florida Blue

An Independent Licensee of the Blue Cross and Blue Shield Association

EMPLOYER APPLICATION (True Group Application)

☐ New Business ☒ Renewal Business ☐ Other

I. Group Information

Group # (Florida Blue): **98854** (Florida Blue HMO): **98854**

A. Name of Group: **CITY OF POMPANO BEACH FLORIDA**

Nature of Business: **EXECUTIVE OFFICES** SIC Code: **9111**

Mailing Address: **100 W ATLANTIC BLVD POMPANO BEACH,FL 33060-6099**

Email Address: **Cindy.Lawrence@copbfl.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 a Policy) by Blue Cross and Blue Shield of Florida, Inc., D/B/A Florida Blue and/or Health Options, Inc., D/B/A Florida Blue HMO. Upon acceptance of this application by Florida Blue and/or Florida Blue HMO, it will become part of the Policy issued to the applicant named above.

C. Prior Insurance Carrier: Insurance **UNICARE**

HMO **N/A**

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: **SELF INSURED**

II. Effective Date/Eligibility Information

A. Effective Date of this Policy shall be **10/01/1999**

Effective Date of this Change to the Policy shall be **10/01/2021**

This Policy may be terminated by the applicant or Florida Blue/Florida Blue HMO 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 **30** 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 **1st of the month** after **See Spec Ins** days of employment, so long as the eligible employee submits an application to Florida Blue/Florida Blue HMO within 30 days of the date the individual first meets the applicable eligibility requirements.

E. At least **65** % 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 Florida Blue/Florida Blue HMO participation requirements.

F. Florida Blue/Florida Blue HMO 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 Florida Blue/Florida Blue HMO. Applicant agrees to furnish any such request.

G. Employer Contribution: Employee: **100** % Dependents: **50** %

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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: **BlueCare NFQ LG GRP Plan 55 - Cust**

Rx Option *(indicate copayments)*: **BlueCare Rx OOP INT $10/$20/$40C - STD**

Benefit Period : **01/01/2021 - 12/31/2021**

Deductible :

Per Person: **$250 / Not Applicable**

Per Family: **$500 / Not Applicable**

Pre-Existing: **N/A**

Coinsurance:

In-Network / Participating: **90% / 10%**

Out-of-Network/Non-Participating: **Not Applicable / Not Applicable**

Office Visit Copay:

Family Physician: **$20**

All Other Providers: **$20 Copayment**

Rates

Employee	**$657.84**	Employee/Spouse	**N/A**	Employee/Child(ren)	**N/A**	Family	**$1763.07**
Spouse	**N/A**	Child(ren)	**N/A**	Spouse/Child(ren)	**N/A**	Employee + 1	**N/A**

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☒ Single Plan ☐ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
BlueChoice Physician Copay Plan 0727 - Cust	**BlueScript Rx OOP Int $10/$20/$40C - STD**

Benefit Period : 01/01/2021 - 12/31/2021

Deductible :

Per Person	$500 / Combined w/ In-Network
Per Family	$750 / Combined w/ In-Network
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	70% / 30%

Office Visit Copay:

Family Physician	$25
All Other Providers	$25 Copayment

Rates

Employee	$968.42	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	$2223.67
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	N/A

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 Florida Blue'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.

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, Florida Blue/Florida Blue HMO 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: Florida Blue: ANNUAL REFND NO SPEC STOP LOSS

HMO: ANNUAL REFND NO SPEC STOP LOSS

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 Florida Blue/Florida Blue HMO for this or any other purpose, nor shall Florida Blue/Florida Blue HMO be responsible for such notification to retirees). 2) Deliver to covered enrollees identification cards and certificates of coverage furnished by Florida Blue/ Florida Blue HMO. 3) Notify Florida Blue/Florida Blue HMO 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 Florida Blue/Florida Blue HMO form. Applications from absentees will be accepted at Florida Blue/Florida Blue HMO 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 Florida Blue/Florida Blue HMO as specified in this application.

B. 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.

C. 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.

D. If applicant chose an HSA, HRA or FSA integrated arrangement with Florida Blue's preferred administrator, applicant agrees to obtain from each employee enrolling in a health plan issued or administered by Florida Blue and establishing an HSA, HRA or FSA in conjunction therewith, the employee's signed HIPAA compliant authorization form that authorizes Florida Blue to disclose to Florida Blue'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 Florida Blue does not provide banking or administrative services for HSA, HRA of FSAs and that Florida Blue 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.

E. 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.

F. Applicant agrees to receive group invoices and other communications from Florida Blue/Florida Blue HMO electronically through your BlueBiz account. You agree to keep your email address up-to-date in order to access and receive required communications through your BlueBiz account. Applicant understands that failing to update your email address may result in delay of notification of important information including premium invoices. [Applicant may change this mailing preference at any time by calling Florida Blue/Florida Blue HMO or logging into your BlueBiz account.]

G. If applicant is applying for BlueOptions which includes a pharmacy plan with an Exclusive Provider Provision (EPP), applicant acknowledges that all eligible employees live, reside or work in the Service Area. Applicant acknowledges receipt of 1) a description of the exclusive providers; 2) a description of the exclusive provider provisions including coinsurance and deductible levels if providers other than exclusive providers are used; 3) a description of coverage for emergency and urgently needed care and other out-of-service area coverage; 4) a description of limitations on referrals to restricted exclusive providers and to other providers; and 5) a description of Florida Blue's quality assurance program and grievance procedure. Applicant further acknowledges that applicant understands the restrictions of the BlueOptions Exclusive Provider Organization for pharmacy plans that include this provision.

VII. Final Premiums, Benefits and Effective Dates are Subject to Approval by Florida Blue Corporate Headquarters

Issuance of the Policy by Florida Blue/Florida Blue HMO will be deemed acceptance of this application.

Date	Signature of Applicant	Print/Type Name & Title

Date Florida Blue and/or Florida Blue HMO Licensed Agent (Print)

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Signature of Agent	Agent License Identification Number