BlueCross BlueShield Nebraska

PO Box 3248
Omaha, NE 68180-0001

League Insurance Government Health Team

Participation Agreement and Subgroup Application

The undersigned employer/member hereby requests that it be approved as a Participant in the League Insurance Government Health Team Member Health Plan (the "Plan") underwritten by Blue Cross and Blue Shield of Nebraska (BCBSNE), and that insurance become effective as of the date shown on this Subgroup Application, or as of the date specified by BCBSNE, whichever is later, and continue as long as the undersigned employer/member remains an eligible Participant. The benefits provided by such insurance shall be in accordance with the Participant's specified Benefit Option(s) and shall be subject to the terms of the Master Group Contract issued to the League Insurance Government Health Team (LIGHT) by BCBSNE.

The undersigned employer/member agrees to furnish BCBSNE all information required by it for its administration of the Plan, including paying when due, the cost of all insurance premiums. The undersigned employer/member further understands that if premiums are not paid before the expiration of the grace period, all insurance coverage will automatically terminate.

Employer or LIGHT Member Signature _____ Title _____ Date _____

☐ **NEW** ☑ **RENEWAL or REVISION** **Account/Group Number:** **102837**

EFFECTIVE DATE OF COVERAGE

This coverage shall be effective on 7/1/2024 provided this Subgroup Application is accepted by BCBSNE and payment of the charges is made as provided in this Subgroup Application. Changes in the terms of this Subgroup Application may be made only in conjunction with the renewal of the Master Contract, unless our prior approval is obtained for an off-anniversary change.

APPLICANT INFORMATION

A. Parent Account: League Insurance Government Health Team

Applicant/Employer City of Crete
(If Employer Name is over 40 characters, please provide an abbreviated 40 character name)

Physical Address: (must be a Nebraska address)
243 E 13th St
(Street)
Crete, NE 68333-2238
(City, State, ZIP Code)

Mailing/Billing Address (if different than physical):
_____
(Street) (PO Box)
_____
(City, State, ZIP Code)

Employer Tax Identification Number (EIN): 47-6006154

Market Affiliation Code: 10820

NAICS Code: 921110

Group Leader/Group Health Plan Primary Contact

Name: Tom Ourada
Title: City Administrator
Phone: 402-826-4132
Email: Tom.Ourada@Crete.NE.Gov
Allow BluesEnroll Access? ☑ Yes ☐ No

Billing Contact (if different)

Name: Wendy Thomas
Title: Finance Director
Phone: 402826-6418
Email: Wendy.Thomas@Crete.NE.Gov
Allow BluesEnroll Access? ☑ Yes ☐ No

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: Savannah Anderson

Title: Human Resources Coordinator

Phone: 402-826-4313

Email: Savannah.anderson@Crete.NE.Gov

Allow BluesEnroll Access? ☑ Yes ☐ No

NOTE: If you have additional Authorized Plan Contacts (APC), please enter them on page 6.

B. Does the Subgroup Applicant/Employer authorize Blue Cross and Blue Shield of Nebraska to administer all dependent coverage requests involving court-ordered alternate recipients, which will include reviewing and determining dependent coverage and notifications required by OBRA '93 regarding Qualified Medical Child Support Orders (QMCSO)?

☑ **Yes** ☐ **No**

C. **Do you meet the definition of "Small Employer" as defined below?** ☐ **Yes** ☑ **No**

Small employer shall mean any person, political subdivision, firm, corporation, limited liability company, partnership, or association that is actively engaged in business that, on at least 50% of its working days during the preceding calendar quarter, employed at least two and no more than 50 eligible employees, the majority of whom were employed within Nebraska. Eligible employee shall mean an employee who works on a full-time basis and has a normal work week of 30 or more hours.

ELIGIBILITY AND ENROLLMENT

A. **Employee Eligibility:** An employee will be eligible for coverage on the first of the month following 0 days of service (not to exceed 60 days) and for so long as such employee continues to work a minimum of 30 hours per week (17½ hours or more) on a regular calendar year basis.

If "0" Waiting Period days above, employee's coverage will be effective (please check):

☒ The first of the month following the 1st day of work.

☐ The first of the month following the 1st day of work, unless that day is the first of the month, then coverage is effective on the first of that month.

☐ the 1st day of work.

Dependents enrolling for coverage at the same time as the employee will become effective on the same day as the employee.

If an otherwise eligible employee is not actively at work on his or her normal effective date for other than personal health reasons, coverage for that employee will go into effect on the first of the month 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 ____ employees not actively at work. Please list the names and corresponding Social Security Numbers on the lines listed below.

_____

_____

Except as provided and limited below, if an employee is not actively at work or fails to meet the minimum weekly working hours requirement for four (4) consecutive weeks, the employee's coverage will be terminated. The "actively at work" requirement shall be met under the following three circumstances: (1) the employee is actively performing the customary duties, responsibilities, and obligations of the role which the employee is employed to perform; (2) the employee is on leave under the Family and Medical Leave Act (FMLA), whether paid or unpaid; and/or (3) the employee is on an approved paid leave. The minimum weekly working hours requirement is waived for all periods in which the employee is on FMLA leave, but shall apply in all other circumstances, including periods of approved paid leave. Where an employee is on approved paid leave, to meet the minimum weekly working hours requirement, the employee must have available and use paid leave equal to or in excess of such requirement.

LIGHT employer members are required under the LIGHT Membership Agreement to notify Blue Cross and Blue Shield of Nebraska of any changes to the eligibility for coverage of an employee or an employee's dependent within thirty (30) days of such change. Certify the Applicant's understanding of these eligibility requirements and the Applicant's obligations by checking the boxes below:

☒ I understand the employee eligibility requirements as stated above.

☒ I understand that as an LIGHT employer/member, the Applicant is required to report any changes to the eligibility of an employee or an employee's dependent within thirty (30) days of such change.

B. Consolidated Omnibus Budget Reconciliation Act (COBRA) / Employee Retirement Income Security Act (ERISA)

Is the Subgroup Applicant/Employer subject to COBRA, as amended, during this calendar year?* ☒ Yes ☐ No

If yes, does the Subgroup Applicant/Employer have a COBRA Administrator? ☒ Yes ☐ No

Does the Subgroup Applicant/Employer have a direct relationship with the vendor? ☒ Yes ☐ No

Please provide the name of the COBRA Administrator: WEX

* A Subgroup Applicant/Employer is subject to COBRA if it normally employed twenty (20) or more employees on a typical business day during the preceding calendar year.

C. **Enrollment Data:**

The following is from and agrees with your payroll and personnel records:

1.	Total eligible employees on the payroll on the effective date of the contract	62
2.	Eligible employees not enrolling due to other group coverage, Medicare, or Medicaid	8
3.	Eligible employees not enrolling due to individual coverage, other or unknown reasons	0
4.	Total employees enrolling	54
5.	Total employees eligible minus valid waivers (1. minus 2.)	54
6.	Gross percentage of employees enrolling (Total enrolling/total eligible 4. ÷ 1.)	.87
7.	Net percentage of employees enrolling (Total enrolling/Total employees eligible minus valid waivers 4. ÷ 5.)	-7.13

D. **Medical Coverage - Rating**

Subgroups will be medically underwritten and offered rates based upon medical underwriting. The rating structure is a 15-tier rating structure and the subgroup will be quoted the rates depending on the tier it falls into, based on medical experience. A subgroup must provide notification to the LIGHT and BCBSNE at least 60 days in advance of the annual anniversary for enrollment if the subgroup intends to terminate coverage under the Plan for a subsequent Plan year. If a subgroup cancels medical coverage, it will not be allowed to reapply for Plan coverage for a period of 24 months from the date of cancellation.

The subgroup must contribute a minimum of 50% of the employee cost of the Plan for all eligible employees enrolled in the subgroup. The subgroup must meet minimum participation requirements of 75% of eligible employees, less valid waivers, but with no less than 25% of total eligible employees, or 50% of total eligible employees.

E. **Late/Open Enrollment:**

Late enrollment is allowed only during the month prior to the annual renewal date, which is the month of June each year for a July 1 effective date.

F. **Other eligibility and enrollment provisions:**

COVERAGE ENDS ON THE LAST DAY OF THE MONTH

BENEFIT PLANS AND NETWORK OPTIONS

Groups with 2-49 enrolled employees can select up to two medical plan options and any combination of the three network options.
Groups with 50+ enrolled employees can select up to three medical plan options and any combination of our three network options.

Health Coverage Options:

☑ PPO Option 1 ☐ PPO Option 2 ☐ PPO Option 3
☐ HSA Option 1 ☐ HSA Option 2 ☑ HSA Option 3 ☐ HSA Option 4

Make a network selection below:

☑ NEtwork BLUE ☐ Blueprint Health ☐ Premier Select BlueChoice

Dental Coverage Options:

☐ Option 1 ☐ Option 2

Name of HSA Administrator, if applicable: Union Bank and Trust

Name of HRA Administrator, if applicable: Mid-America Benefits Inc.

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 will not change prior to 7/1/2025 as long as BCBSNE underwriting guidelines are met. This rate guarantee is subject to the Applicant continuing to meet our underwriting guidelines.

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: PPO OPT 1
Rx Option: 1
Network: NETWORK BLUE

	Employer Contribution			
	Percent	or Fixed Amount	Total Monthly Charge
☑ Employee	95		855.03
☑ Employee & Spouse	80		1752.81
☑ Employee & Child(ren)	80		1496.30
☑ Family	80		2479.59

Plan Option: HSA OPT 3
Rx Option:
Network: NETWORK BLUE

	Employer Contribution			
	Percent	or Fixed Amount	Total Monthly Charge
☑ Employee	95		655.15
☑ Employee & Spouse	80		1343.06
☑ Employee & Child(ren)	80		1146.51
☑ Family	80		1899.94

Plan Option: PPO OPT 1 (UNION)
Rx Option:
Network:

	Employer Contribution			
	Percent	or Fixed Amount	Total Monthly Charge
☑ Employee	100		855.03
☑ Employee & Spouse	85		1752.81
☑ Employee & Child(ren)	85		1496.30
☑ Family	85		2479.59

Plan Option: HSA OPT 3 (UNION)
Rx Option:
Network:

	Employer Contribution			
	Percent	or Fixed Amount	Total Monthly Charge
☑ Employee	100		655.15
☑ Employee & Spouse	85		1343.06
☑ Employee & Child(ren)	85		1146.51
☑ Family	85		1899.94

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 Participation Agreement and Subgroup 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 Participation Agreement and Subgroup Application 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: S. Jane Limbach ☐ Group Contact ☒ Agent
Agency if applicable: McInnes Group, Inc.
Title: Account Manager
Phone Number: 913-831-0999
Email: jane@Mcinnesgroup.com
Allow BluesEnroll Access? ☑ Yes ☐ No

Name: Dennis Maggart ☐ Group Contact ☒ Agent
Agency if applicable: McInnes Group, Inc.
Title: Executive Vice-President
Phone Number: 913-831-0999
Email: Dennis@Mcinnesgroup.com
Allow BluesEnroll Access? ☑ Yes ☐ No

Name: Troy Shreve ☐ Group Contact ☒ Agent
Agency if applicable: Benefit Management/OCI
Title: Agent/Owner
Phone Number: 402-420-7776
Email: TShreve@Benefit-Management.Com
Allow BluesEnroll Access? ☑ Yes ☐ No

Name: Savannah Anderson ☒ Group Contact ☐ Agent
Agency if applicable:
Title: Human Resources Coordinator
Phone Number: 402-826-4313
Email: Savanah.Anderson@Crete.Ne.Gov
Allow BluesEnroll Access? ☑ Yes ☐ No

Name: Wendy Thomas ☒ Group Contact ☐ Agent
Agency if applicable:
Title: Finance Director
Phone Number: 402-826-6418
Email: wendy.thomas@crete.ne.gov
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.

CERTIFICATION AND SIGNATURE

I have read the entire Participation Agreement and Subgroup Application and any supplement(s) thereto. To the best of my knowledge, there have been no material misrepresentations. I further agree and understand that any individual Enrollment Forms submitted to or accepted by the Subgroup employer/member which do not meet the provisions specified hereunder may be declared null, void, and without effect. I UNDERSTAND THAT LEAGUE GROUPS MUST BE MEMBERS OF THE LEAGUE OF NEBRASKA MUNICIPALITIES (LONM) IN ORDER TO MAINTAIN ELIGIBILITY FOR THIS PLAN AND THAT THE SUBGROUP MUST ENTER INTO A MEMBERSHIP AGREEMENT WITH LIGHT TO BE ELIGIBLE TO PARTICIPATE IN THE PLAN. I understand the possible effect of canceling our current group health plan prior to receiving final approval from BCBSNE. I understand that it is the Subgroup employer/member's responsibility to evaluate this and other employee benefits. The Subgroup employer/member should consult its own legal and other counsel regarding tax and benefit implications. Subgroup employer/member is not relying on LIGHT, LONM or BCBSNE with respect to any aspect of the Subgroup employer/member's provision of health and dental benefits to Subgroup employer/member or its employees.

David Bauer _____ Mayor _____ _____

Printed Name of Applicant | Printed Title | Date

_____

Signature of Applicant/Group

BROKER/AGENT CERTIFICATION:

I have read the entire Participation Agreement and Subgroup Application and any supplement(s) thereto. I certify that I have verified the information in this Participation Agreement and Subgroup Application with the Applicant and to the best of my knowledge, it is true and accurate and there have been no material misrepresentations.

_____ _____

Broker/Agent Printed Name | Date

_____

Signature

ACCEPTANCE BY BLUE CROSS AND BLUE SHIELD OF NEBRASKA:

☐ This Application is accepted.

☐ This Application is accepted with the following changes: _____

_____

_____

_____ _____ _____

Signature | Title | Date

The noted changes are acceptable. _____ _____

Signature of Applicant | Date